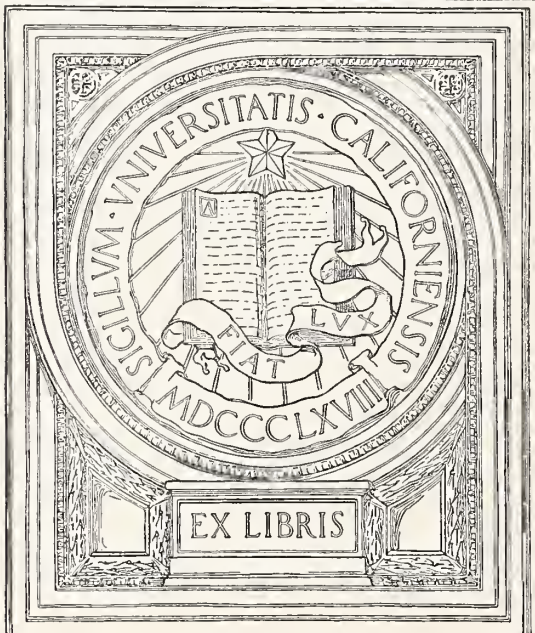
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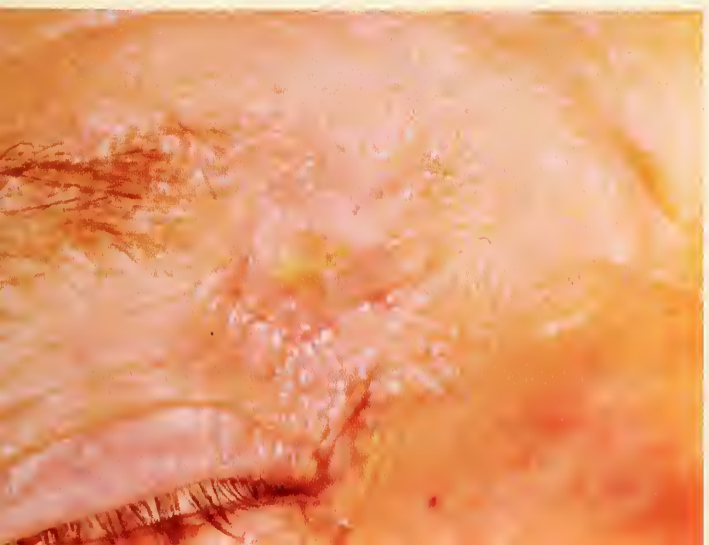
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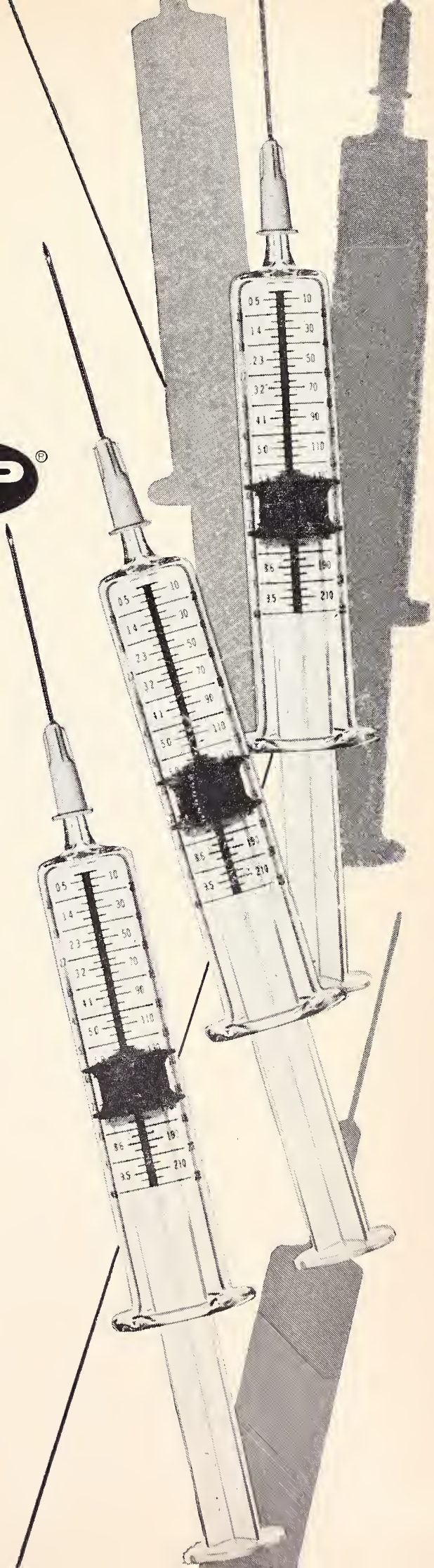


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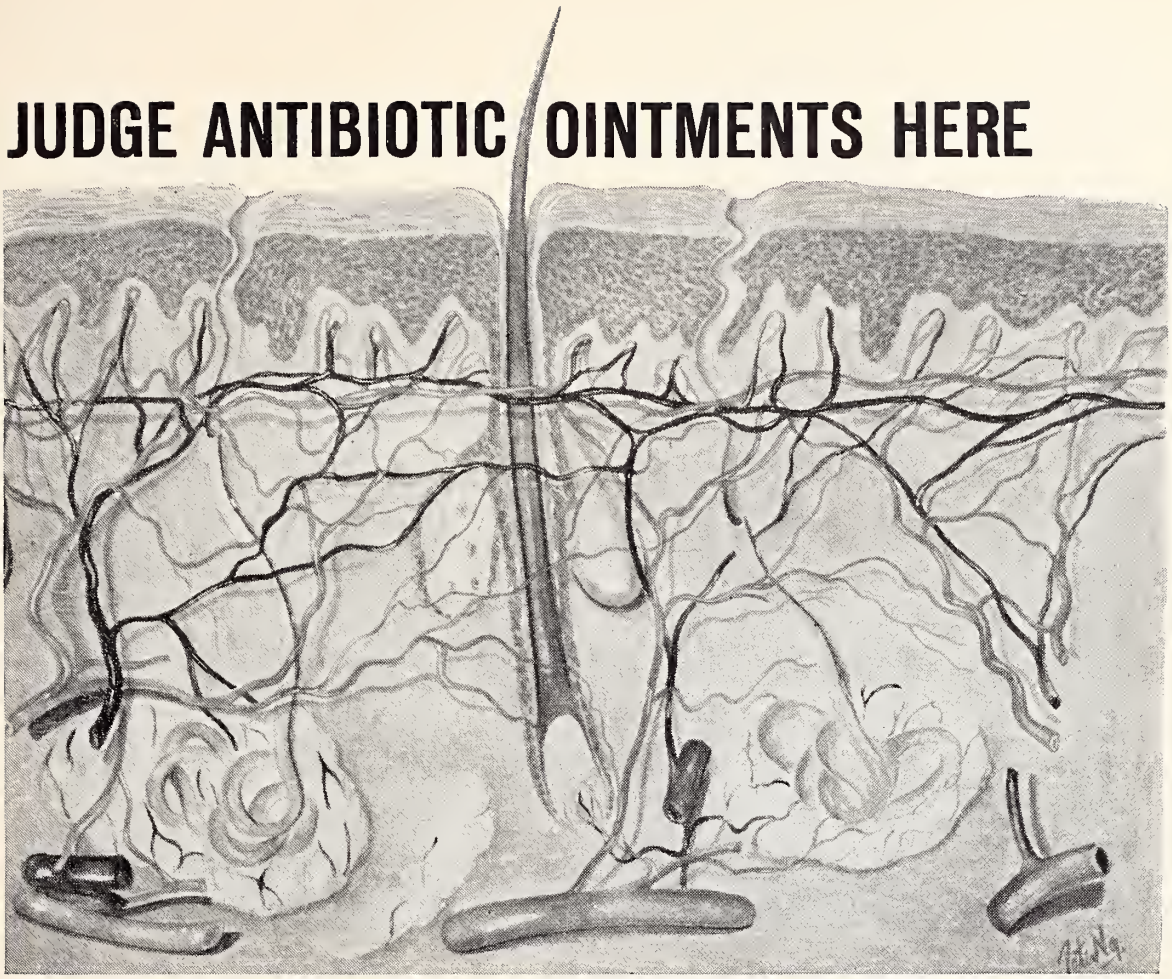


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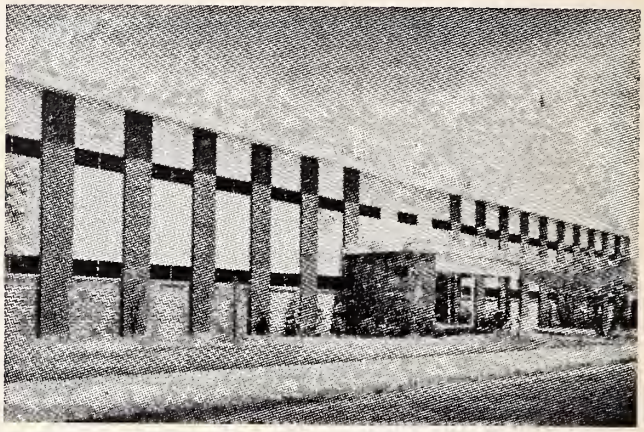
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Editor's Page

THE NITTY GRITTIES

No one believes that either the Executive Committee, the officers, or the Board of Directors ever does any work. And problems — why should they have problems? After all, aren't they elected to office as a "reward" for all the problems they have faced and solved during the past years? "Let's be good to Ole Doe — he's worked hard! Let's elect him to an office!"

And then, the Nitty Gritties! Now decisions must be made for the ultimate and future benefits of the Arizona Medical Association and not for personal aggrandizement. Now we almost forget to think — we almost abandon the basic rules which permit us to treat disease successfully — we almost throw away any business acumen we may have ever possessed — we almost close our ears to any advice whatsoever — we become almost emotional in our deliberations — we plumb depths rarely reached — and some decisions are made.

An inflexible budget was made and accepted. A new building for ArMA was conceived and planning was initiated so that in future years ArMA might better cope with rising administrative costs. Decisions were made in hours of executive session that touched and changed and affected each and every one of us. The Nitty Gritties!

I am not naive — I have been down a few roads. Neither am I blasé — I am still capable of being impressed — and I am overwhelmingly impressed with the Executive Committee of the ArMA Board of Directors which sits in session for these next twelve months — with the scope of their planning — their grasp of our problems — their willingness to work — and with their complete personal honesty.

It wasn't easy for anyone. I personally am proud that I could be even a small part of it!

Roland F. Schoen, M.D.
Editor

New

Therapeutic breakthrough in non-narcotic control of the pain of

Tegretol®
carbamazepine

trigeminal neuralgia

Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the dru should be discontinued.
2. Liver function tests must be performed at regular intervals during tre ment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonor etry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated w Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytos eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary frequency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urin impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, erythe multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexi dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular effe are drug-related is not known. However, some of these complications h resulted in fatalities.) The necessity for discontinuing the drug should be dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with meals if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the do should be increased in one-half tablet (100 mg.) increments every 12 hou until freedom from pain is achieved. To relieve pain, between 200 mg. an 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should be made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-A
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BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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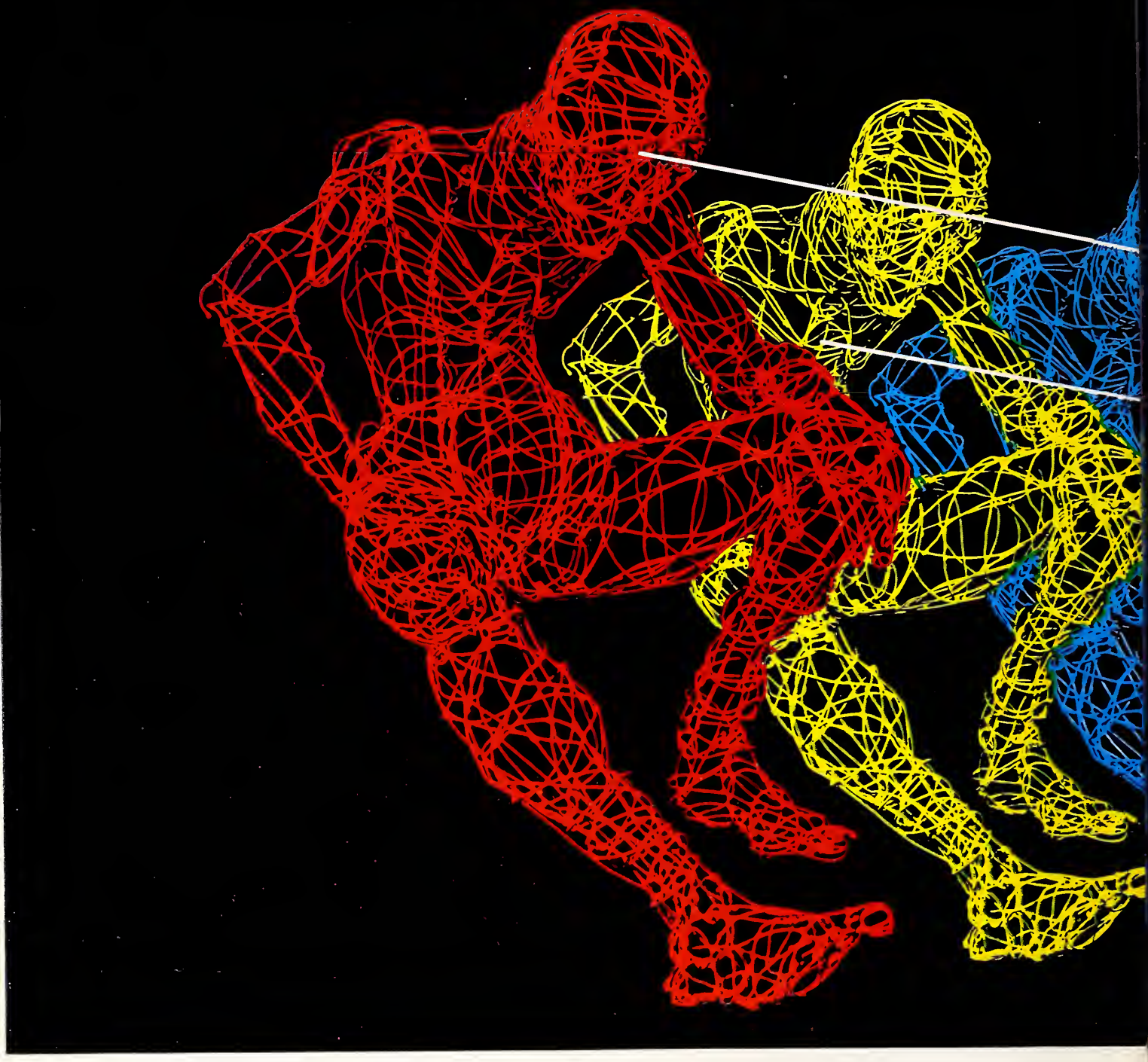
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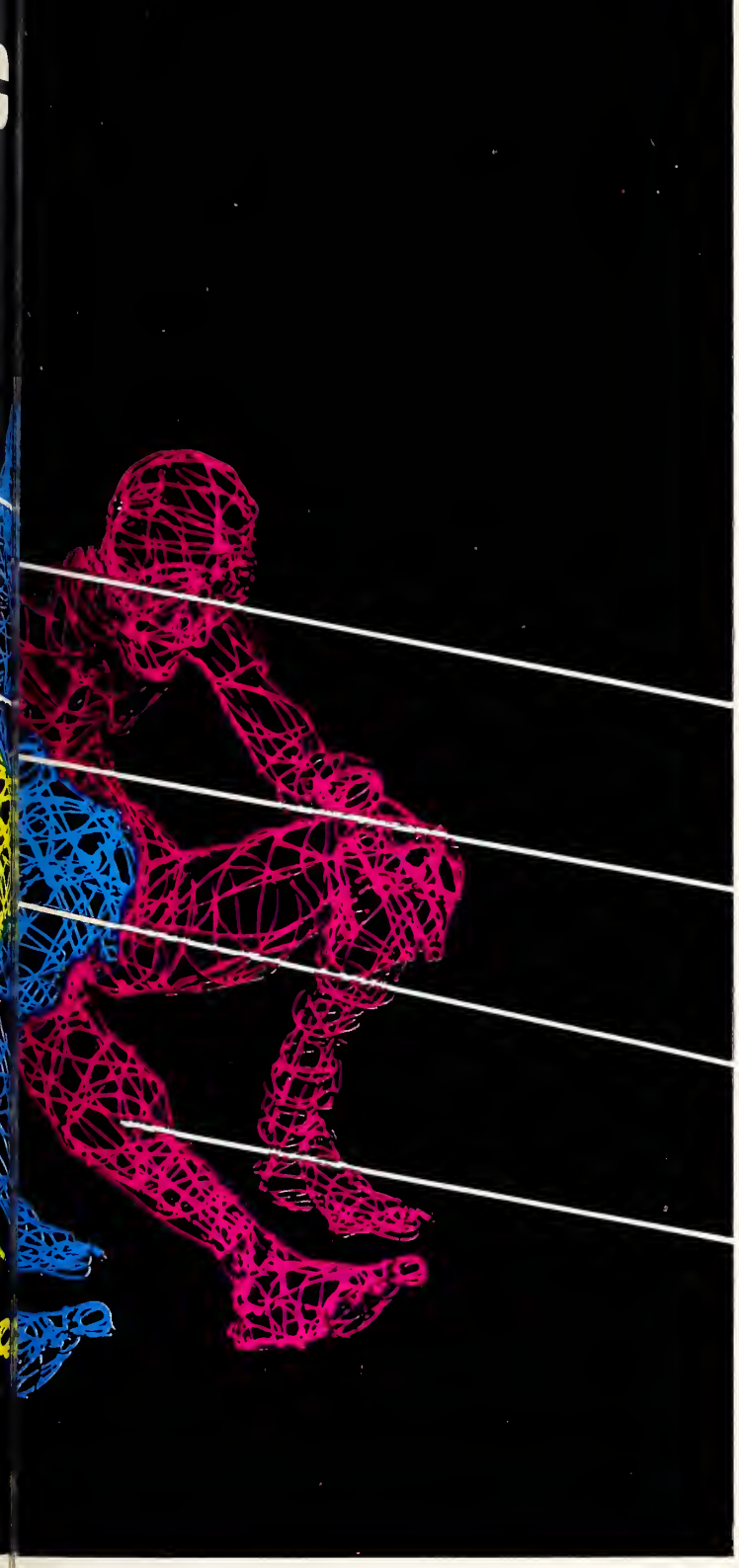
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

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Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032668]

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Alternate Delegate to AMA—Seymour I. Shapiro, M.D. Bldg. 24, Med. Sq., 1601 N. Tucson Blvd., Tucson, Arizona
Past President—Arnold H. Dysterheft, M.D. McNary Hospital, McNary, Arizona

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Southern District—William C. Scott, M.D. 45 N. Tucson Blvd., Tucson, Arizona
Southern District—Hermann S. Rhu, Jr., M.D. 5th and Alvernon Streets, Tucson, Arizona
Southwestern District—Howard W. Finke, M.D. Magma Copper Hospital, Superior, Arizona

SOCIEDAD MEDICA DE ESTADO UNIDOS DE NORTE AMERICA Y MEXICO

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MEMBERS ARE URGED TO BRING MATTERS OF INTEREST AND CONCERN TO THE CHAIRMEN OF THE APPROPRIATE COMMITTEE OR TO THE ATTENTION OF ANY MEMBER OF THE BOARD OF DIRECTORS.

AN INVOLVED MEMBERSHIP IS THE BASIS FOR AN EFFECTIVE ASSOCIATION.

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COUNTY MEDICAL SOCIETY OFFICERS 1968-69

APACHE: Arnold H. Dysterheft, M.D., President, McNary Hospital, McNary; Paddy R. Garver, M.D., Secretary, P.O. Box 919, Show Low.

COCHISE: Robert E. Montgomery, M.D., President 1101 San Antonio Dr., Douglas; James M. Gilbert, M.D., Secretary, Copper Queen Hospital, Bisbee.

COCONINO: Gerald T. McMahon, M.D., President, 1355 North Beaver, Flagstaff; David D. Smith, M.D., Secretary, 715 North Beaver, Flagstaff.

GILA: Jesse E. Jacobs, M.D., President, Box Z, Miami; T. E. Matheson, M.D., Secretary, Miami-Inspiration Clinic, Miami.

GRAHAM: Frederick W. Knight, M.D., President, 618 Central Avenue, Safford; Jack L. Bennett, M.D., Seeretary, 618 Central Avenue, Safford.

GREENLEE: Robert V. Horan, M.D., President, Morenci Hospital, Morenci; James W. Gilbert, M.D., Seeretary, P. O. Box 1537, Clifton.

MARICOPA: Arthur R. Nelson, M.D., President, 926 E. McDowell Rd., Phoenix; Donald F. Schaller, M.D., Secretary, 55 W. Catlina Drive, Phoenix.
(Society Address: 2025 North Central Avenue, Phoenix)

MOHAVE: George M. Clarke, M.D., President, 412 East Oak Street, Kingman; John J. Standifer, M.D., Secretary, 412 East Oak Street, Kingman.

NAVAJO: Leo L. Lewis, M.D., President, P. O. Box AT, Winslow; George G. Bertino, Jr., M.D., Secretary, 1500 Williamson Avenue, Winslow.

PIMA: John A. Wilson, M.D., President, 1601 N. Tucson Boulevard, Tucson; Seymour I. Shapiro, M.D., Secretary, Bldg. 24, Med. Square, 1601 N. Tucson Blvd., Tucson.
(Society Address: 2555 East Adams Street, Tucson)

PINAL: William J. Clemans III, M.D., President, 1616 Main Street, Florence; Robert L. Hyde, M.D., Secretary, 1616 Main Street, Florence.

SANTA CRUZ: Stephen A. Letourneaux, M.D., President, 711 Morley Ave., Nogales; Charles S. Smith, M.D., Secretary, Gebler Building, Nogales.

YAVAPAI: Edward L. Ritter, M.D., President, 533 West Gurley Street, Prescott; William R. Shepard, M.D., Secretary, 1003 Division Street, Prescott.

YUMA: John F. Stanley, M.D., President, 201 First Avenue, Yuma; Dale F. Webb, M.D., Secretary, Avenue A and 24th Street, Yuma.

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President Mrs. Lewis S. Winter (Jean)
1714 E. Rose Lane, Phoenix 85016

President-Elect Mrs. Robert J. Oliver (Nicki)
910 N. Wilmot Road, Tucson

1st Vice President Mrs. Robert P. Mason (Doris)
330 W. Maryland Apt. 107, Phoenix 85013

2nd Vice President Mrs. Evaristo Martinez (Frances)
1172 Country Club Drive, Prescott 86301

Treasurer Mrs. William O. Minturn (Shirley)
6034 N. 38th Place, Scottsdale 85018

Recording Secretary Mrs. Dale F. Webb (Lynn)
2200 E. 25th Place, Yuma 85364

Corresponding Secretary Mrs. Rex O. Vaubel (Eileen)
117 W. Glenn Dr., Phoenix 85021

Director (2 Years) Mrs. Carl Shrader (Ginny)
527 Bertrand, Flagstaff 86001

Director (1 Year) Mrs. John E. Oakley (Helen)
57 A Country Club Dr., Prescott 86301

Director (1 Year) Mrs. Elvie B. Jolley (Mila)
301 Cole Avenue, Warren 85642

CHAIRMEN OF STANDING COMMITTEES 1968-69

AMA-ERF: Mrs. Albert G. Wagner (Helen)
3216 E. Meadowbrook (956-3674), Phoenix 85018

BY-LAWS: Mrs. Charles E. Matheus (Marilyn)
2148 E. 25th St., Yuma 85364

CHAPLAIN: Mrs. J. B. Tucker (Laverne)
700 East 10th St., Casa Grande 85222

COMMUNITY HEALTH: Mrs. Harry D. Bryan
Yuma 85364

FINANCE: Mrs. James L. Parsons
5251 E. Hawthorne, Tucson 85711

GEMS: Mrs. James Alway
1677 E. Maryland, Phoenix 85016

HEALTH CAREERS: Mrs. William Scott (Jean)
340 S. Country Club Rd. (326-5354), Tucson 85716

HAMER EDUCATION LOAN FUND:
Mrs. Alvin L. Swenson (Viki)
5250 Bartlett Circle, Phoenix 85016

HISTORIAN: Mrs. Melvin Phillips (Jean)
1001 Norris Road, Prescott 85018

INTERNATIONAL HEALTH: Mrs. Rexford Peterson (Dell)
6130 N. 52nd Place (945-9250), Paradise Valley 85251

LEGISLATION: Mrs. George S. Enfield (Ro)
1226 E. Cambridge Ave. (265-2507), Phoenix 85016

MENTAL HEALTH: Not Filled

NOMINATING: Mrs. Elvie B. Jolley (Mila)
301 Cole Ave. Warren 85642

PARLIAMENTARIAN: Mrs. Clare W. Johnson (Mary Anne)
318 W. Lawrence Rd. (266-1410), Phoenix 85013

PUBLICATION: Mrs. Hubert R. Estes (Mickie)
9035 E. Woodland Road (298-1289), Tucson 85715

SAFETY-DISASTER PREPAREDNESS: Not Filled

WACAMA LIAISON: Not Filled

CONVENTION: Not Filled

COUNTY PRESIDENTS 1968-69

MARICOPA Mrs. George L. Hoffmann (Julie)
900 W. Mountain View Dr., Mesa 85201

COCONINO Mrs. Darius Benham (Esther)
527 Bertrand, Flagstaff 86001

YUMA Mrs. Paul Slosser (Betty)
701 E. 8th Avenue, Yuma 85364

PIMA Mrs. Richard F. Dahlen
3210 E. Via Palos Verdes, Tucson 85716

YAVAPAI Mrs. Bruce Culvahouse (Mary)
c/o VA Hospital, Whipple 86301

GILA Mrs. David Gilbert (Wanda)
P.O. Box 310, Payson 85541

ArMA Reports

BOARD OF DIRECTORS

Meeting of the Board of Directors of the Arizona Medical Association, Inc., held Tuesday, April 23, 1968, in the Convention Center of the Safari Hotel, Scottsdale, Arizona, convened at 10:00 A.M., Richard O. Flynn, M.D., Vice President and Chairman, presiding.

ROLL CALL

PRESENT: Drs. Beckwith, Harry S.; Brooks, Jack E.; Cloud, Daniel T.; Derickson, Philip G.; Dew, Philip E.; Dexter, Richard L.; Dudley, Jr., Arthur V., President-Elect; Dysterheft, Arnold H., President; Finke, Howard W.; Flynn, Richard O., Vice President and Chairman; Grobe, James L.; Heileman, John P., Secretary; Henderson, Charles E.; Jarrett, Paul B.; Landeen, Fred H., Treasurer; Moody, Deward G.; Price, Robert A.; Rhu, Jr., Hermann S.; Sattenspiel, Edward; Schoen, Roland F.; Standifer, John J.; Steen, William B.; Young, Woodson C.

Counsel: Mr. Jacobson, Edward.

Staff: Messrs. Carpenter, Robert, Executive Secretary—ArMA; Robinson, Bruce E., Assistant Executive Secretary—ArMA; Boykin, Paul R., Executive Secretary—BOMEX.

Guests: Brown, William J. (Jack), AMA Field Service; Dysterheft, Arnold H., M.D., President—Apache County Medical Society; Kahle, John F., M.D., Chairman—Board of Directors ArMPAC; Reed, James M., Director, AMA Communications Division; Zivney, Richard, Associate Broker, Ed Post Realty.

EXCUSED: Dr. Melick, Dermont W.

WELCOME

Dr. Flynn called the meeting to order extending a cordial welcome to those guests in attendance, introducing each.

MINUTE

Approved minute of the meeting of the Board of Directors of this Association held March 10, 1968.

ARMPAC BOARD OF DIRECTORS

Dr. Kahle advised that he was pleased to report the membership in ArMPAC has grown to slightly in excess of 600 this year to date, undoubtedly, the result of component county society cooperation, principally Maricopa, through inclusion of subscriptions with their regular dues billing. Grateful appreciation was expressed. It also appears good attendance may be anticipated at the ArMPAC Banquet, Thursday evening next to hear Senator George Murphy with 115 advance reservations. REPORT RECEIVED.

Eugene A. Savoie, D.D.S. (Tucson) appointed member of the ArMPAC Board of Directors.

BOARD OF DIRECTORS

Arizona Health Planning Authority

Confirmed the nominations of Philip E. Dew, M.D. (Tucson), Ben P. Frissell, M.D. (Phoenix) and Dermont W. Melick, M.D. (Tucson); also, Joseph M. Green, M.D. (Tucson), James M. Kilgore, Jr., M.D. (Phoenix) and Robert Shapiro, M.D. (Phoenix), the latter three certified specialists by the American Board of Psychiatry, one from each group of three to be selected and appointed by the Governor of Arizona a member of the Arizona Health Planning Authority, as provided for in Chapter 162 of the Laws of Arizona — 1968, recently enacted. Governor's Office acknowledges receipt of listing of nominees.

Board of Medical Examiners — Arizona — Vacancy

Nominated John F. Kahle, M.D. (Flagstaff), James T. O'Neil, M.D. (Casa Grande) and Francis M. Findlay, M.D. (San Manuel), one of which shall be selected and appointed by the Governor of Arizona a member of the Board of Medical Examiners of the State of Arizona for a term of five (5) years, effective July 1, 1968, in accordance with Chapter 13, Medicine and Surgery, A.R.S. 1964, to fill a vacancy caused by the expiration of term of Howard W. Finke, M.D. (Superior), ending June 30, 1968.

Board of Medical Examiners — Arizona — Compensation

Determined to institute whatever action is necessary to carry out the intent of the recommendation of the Board of Medical Examiners that the Medicine and Surgery Act be amended to permit of the payment of a per diem of $100.00 and full expenses associate with the activities of both the members of the Board and its Commissioners on Examinations. It was expressed desirable that a member of the medical association be in charge of this particular piece of legislation.

Board of Medical Examiners — Arizona — Finances

Dr. Finke reviewed the present crisis confronting the Board of Medical Examiners as regards its financial position. By action of the Legislature, it has adopted what is referred to as a "line item" budget. This means that the Board must limit its expenditures to the amount of each item of appropriation; further, that it must not exceed what is considered a quarter of the total budgeted item within a given quarter. The Board operates on what is referred to as 90/10 Board of Medical Examiners' Fund, i.e. 90% of its collections are appropriated for the use of the Board and 10% is deposited in the state general fund. This fund approximates $40,000.00 at present. In the final quarter of the fiscal year 1967-68 ending June 30th, there appears insufficient funds allocated for this quarter to carry out its functions unless it is permitted to use some of its surplus; further, at the time of development of its 1967-68 budget, it was not anticipated need for Examination Commissioners as provided in a recent statutory amendment; accordingly, there is no line item of appropriation therefor. Counsel reviewed course of action being pursued which was authorized continued. REPORT RECEIVED.

CENTRAL OFFICE ADVISORY COMMITTEE

ArMA Membership Classification Changes

COCHISE: Charles Dean Kartchner, M.D. (Benson) — Active, granted Associate (dues exempt) account Military Service, effective 1/1/68.

Charles S. Meinstein, M.D. (Ft. Huachuca)—Granted Service (¼ dues) account Full-Time Employment—Ft. Huachuca Armed Services, effective 1/8/68.

MARICOPA: Robert E. T. Stark, M.D. (Phoenix)—

Active, granted Service (¼ dues) account Full-Time Employment — St. Joseph's Hospital, Phoenix, effective 1/1/68.

PIMA: Ronald C. Almgren, M.D. (Tucson)—Active (dues exempt 1966-67 account Financial Hardship), granted Active (dues exempt) account Financial Hardship, effective 1/1/68.

YAVAPAI: Dallas C. Allred, M.D. (Prescott)—Active, granted Associate (dues exempt) account Further Training, effective 1/1/68.

YUMA: Joseph C. Pinto, M.D. (Yuma)—Active, granted Associate (dues exempt) account Residency Training, effective 1/1/68.

David Richard Sussman, M.D. (Yuma)—Granted (New) Associate (dues exempt) account Military Service (1967-69 USPHS Indian Hill Hospital), effective 3/7/68.

Financial Report

Accepted the 1967 Audit (Final) of the accounts of this Association as prepared and presented by Henry and Horne, certified public accountants.

Dr. Landeen reviewed the financial report for March, 1968, setting forth total "INCOME" received amounting to $17,450.91 ($204,375.00 budgeted of which a total of $170,785.89 has been collected) and "EXPENDITURES" of $17,429.16 ($202,989.00 budgeted of which a total of $47,365.48 has been expended). ACCEPTED.

Authorized the following additional appropriations out of contingency ($1,386.00):

500F Executive Committee	$125.00	
500L Medical Economics	300.00	
500Z Resolution No. 15	25.00	$450.00

Building Program

Prepared and submitted for review was a study of possible building sites and building construction costs within the Phoenix area taking into account airport and freeway accessibility. The data was compiled with the cooperation of architects Guirey, Srnka & Arnold (building-lease proposal) and Richard Zivney, Associate Broker of Ed Post Realty, the latter being present. Discussion ensued and Mr. Zivney made himself available for questions which were answered. Dr. Grobe offered for sale two parcels of land approximating 37,500 square feet at his cost ($50,000.00). They are bordering an access freeway road off Black Canyon Highway in the vicinity of West Bethany Home Road in Phoenix.

Resolutions Nos. 6, 7 and 8, previously authorized prepared by the Treasurer, providing for the suggested building program, budget and fund rededication, proposed to be introduced in the forthcoming annual meeting of the House of Delegates, were reviewed. If Resolution 6 is not favorably considered and passed, Resolutions 7 and 8 will be withdrawn.

1968-69 Board and Committees

Adopted the following meeting schedule for the fiscal year 1968-69:

Board of Directors

May 26, 1968
July 14, 1968
September 8, 1968
November 10, 1968
January 12, 1969
March 9, 1969
April (Annual) 22, 1969

Executive Committee

May 25, 1968
July 13, 1968
September 7, 1968
November 9, 1968
January 11, 1969
March 8, 1969

Benevolent and Loan Fund Committee

June 23, 1968

Governmental Services Committee

July 21, 1968
October 6, 1968
December 8, 1968
February 2, 1969
April 13, 1969

Legislative Committee

August 11, 1968
October 20, 1968
December 22, 1968
February 9, 1969

Medical Economics Committee

June 30, 1968
October 27, 1968
December 29, 1968
February 23, 1969

Professional Committee

June 9, 1968
October 13, 1968
December 15, 1968
February 16, 1969

GOVERNMENTAL SERVICES COMMITTEE

Title XIX — Legislative Council

Received report on conference with Legislative Council to commence draft of Title XIX legislation for Arizona. It is anticipated the measure will be completed by the end of April and presented to the Joint Legislative Committee of the Arizona Senate and House. A further conference at that time is anticipated to which ArMA will be invited.

Title XIX — Demonstration Project

Dr. Grobe presented the format of a proposed demonstration project for an underwritten program of medical care for Categorical Assistance Recipients to be financed and matched with Title XIX funds. The project would be under the administrative direction of the Arizona State Health Department acting as the single state agency and underwritten by Arizona Blue Cross-Blue Shield. The location: Pima County including Tucson; estimated population 328,000 (3% Negro 9,840 — 2.8% Indian 9,180 — 16.7% Spanish-American 54,800 — 77.5% White 254,180); Categorical Assistance Recipients (Titles I, IV, X and XIV): Old Age Assistance 2093 — Aid to Dependent Children 7763 — Aid to Blind 70 — Aid to Disabled 1005. Objectives:

1. The study would assist the legislature of the State of Arizona to predetermine its costs for an underwritten Title XIX program for Categorical Assistance Recipients.
2. The demonstration would determine the feasibility of providing Blue Cross and Blue Shield benefits to indigent segments of the public at the same time providing equality of care for both the indigent

and other segments of the public.

3. The demonstration would reveal patterns of medical care utilization in the four major ethnic groups which reside in Pima County in a ratio similar to that of the State of Arizona.
4. The study would determine the amount of family planning undertaken by private physicians in AFTC families.
5. The study would produce evidence of the effect of a full-blown Title XIX program on the medical school, state institutions such as the Crippled Childrens' Hospital, and private care institutions.

Scope of benefits:

1. In-patient hospital care covering semi-private accommodations and full ancillaries based on Blue Cross cost formulae.
3. Out-patient diagnostic services wherever rendered when prescribed by a physician.
3. The usual, customary and reasonable in-patient physicians' services during the thirty-day spell of illness.
4. Physicians usual, customary and reasonable home and office calls up to twenty-four in any calendar year. (Including family planning services.)
5. Skilled nursing home care for a period of ninety (90) days based on Title XVIII formula.
6. Prescription drugs — paid on the basis of CHAMPUS reimbursement (Actual cost plus $2.00 professional fee per prescription).

Administration procedures by each (Arizona State Department of Health, Department of Health, Education and Welfare (U.S.) and the Blue Cross-Blue Shield) were outlined. Estimated costs in the three categories on basis of scope of benefits proposed would be: OAA (2,093) $288,200.00 (monthly premium $11.48); ADC (7,763) $2,035,000.00 (monthly premium $21.85); and ABD (1,075) $293,700.00 (monthly premium $22.77).

Dr. Grobe reviewed his visitation to Washington, D.C. with Wilbur Cohen, HEW Secretary. The program will be undertaken at actual cost insofar as Blue Cross-Blue Shield is concerned. Mr. Cohen suggested family planning should be included. It was reported that the Board of Directors of Pima County Medical Society approved the project.

The Board determined to approve the approach.

MEDICAL ECONOMICS COMMITTEE

CHAMPUS Contract

Ratified execution of Three-Party (U. S. - ArMA - B/S) CHAMPUS contract renewal for the period April 1, 1968, ending March 31, 1969, based upon the customary and prevailing fee concept.

ICA-UCR Fee Concept

Counsel reported the results of special invitational hearing conducted by the joint Senate House Insurance Committee April 5, 1968, before which Drs. Richard O. Flynn, William G. Payne, Carlos C. Craig and himself appeared. Reviewed progress of H. B. 179 which endeavored to provide, by amendment, for the UCR fee concept. It failed of enactment primarily because of the contemplated reorganization of the Industrial Commission by the Legislature which will go into special session for the purpose.

Dr. Grobe offered to provide, if possible through Blue Shield, a written tabulation of doctors fees which might be helpful in support of the UCR concept.

PROFESSIONAL COMMITTEE

Arizona Hospital Advisory Council

Nominated Clarence E. Yount, Jr., M.D. (Prescott), Robert S. Ganelin, M.D. (Phoenix) and John G. Lingenfelter, M.D. (Kingman) one of which shall be selected and appointed by the Commissioner of Public Health (Arizona State) a member of the Arizona Hospital Advisory Council for the term expiring December 31, 1968 (A.R.S. 2-36-422).

Arizona State Hospital

Endorsed program for training in the recognition and treatment of the mentally disturbed geriatric patient, sponsored by the Arizona State Hospital under AOA Title IV grant.

Woman's Auxiliary

Mrs. Elvie B. (Mila) Jolley, President of the Woman's Auxiliary to the Arizona Medical Association, submitted its estimated budget for the fiscal year 1968-69 and requested for 1969 an appropriation similar to that granted in 1968 of $1,000.00. (APPROVED.

SCIENTIFIC ASSEMBLY COMMITTEE

1970 Annual Meeting Location

Marriott's Camelback Inn, Scottsdale, extends invitation to this Association to hold its 1970 meeting at its location. April 29th through May 3rd is available. This hostelry will be completely air conditioned (refrigerated) by that time.

It was reported that Dr. Zeluff recommends the Safari Hotel for 1970. APPROVED.

COMMUNICATIONS

Scholarship Bequest

Authorized acknowledgment with grateful appreciation bequest of Mrs. Marie B. Mallory (Widow) appearing in her Last Will and Testament prepared by Phoenix attorney Alvin E. Larson.

Directed that Counsel be requested to investigate organization of a Charitable Foundation by this Association and proceed forthwith to set it up.

CMA-ERF Comprehensive Health Planning

California Medical Education and Research Foundation extends an invitation to two representatives of this Association to attend a tentatively scheduled meeting on "The Planning Process — Ingredients for Achievement" referable to areawide and regional comprehensive health planning councils activities (P. L. 89-749), July 19-20, 1968. RECEIVED.

NCMS — Nursing

The Medical Society of the State of North Carolina urges support of H. R. 12571 (as revised by H. R. 13096) designed to aid hospital schools of nursing. RECEIVED.

AMA-ERF Medical School Allocations

AMA-ERF allots a sum of $8,054.19 to the University of Arizona College of Medicine contributed in 1967 from physicians throughout the United States and its possessions. The total amount being distributed is $948,907.95. This contribution will be presented to the Dean of the College of Medicine, Merlin K. DuVal, Jr., M.D., during the President's Banquet Friday night.

OTHER BUSINESS

Perinatal and Maternal Mortality Study

Dr. Rhu advised that copies of report on perinatal and maternal mortality study are now available and urged the members to pick up a copy and read it. He solicited comments thereafter by letter and thanked all those a part of this endeavor.

Comprehensive Health Planning — Grant Application

Referred to this Board for consideration is the matter of suggested ArMA sponsorship and applicant for a comprehensive health planning grant. Discussion ensued. It was stated it might be desirable if there was assurance ArMA would be conducting the study. NO ACTION.

MEETING ADJOURNED AT 12:09 P.M.

John P. Heileman, M.D.
Secretary

BOARD OF DIRECTORS

Meeting of the Board of Directors of the Arizona Medical Association, Inc., held Saturday, April 27, 1968, in the French Quarter of the Safari Hotel, Scottsdale, Arizona, convened at 12:08 P.M., Arthur V. Dudley, Jr., M.D., President and Acting Chairman, presiding.

ROLL CALL

PRESENT: Drs. Beckwith, Harry S.; Brooks, Jack E.; Cloud, Daniel T.; Dew, Philip E., Treasurer; Dudley, Jr., Arthur V., President; Dysterheft, Arnold H.; Finke, Howard W.; Grobe, James L.; Heileman, John P., Secretary; Henderson, Charles E.; Jarrett, Paul B.; Landeen, Fred H., Vice President; Moody, Deward G.; Price, Robert A.; Rhu, Jr., Hermann S.; Sattenspiel, Edward; Scott, William C.; Shapiro, Seymour I.; Standifer, John J.; Steen, William B.; Young, Woodson C.

Counsel: Mr. Jacobson, Edward.

Staff: Messrs. Carpenter, Robert, Executive Secretary —ArMA; Robinson, Bruce E., Assistant Secretary—ArMA. Boykin, Paul R., Executive Secretary—BOMEX.

Guests: Dr. Kahle, John F., Chairman, ArMPAC Board of Directors; Mr. Brown, William J. (Jack) AMA Field Representative.

EXCUSED: Drs. Flynn, Richard O., President-Elect; Czerny, Everett W.; Schoen, Roland F.

BOARD ORGANIZATION

Fred H. Landeen, M.D., Vice President, was duly nominated and elected by acclamation Chairman of the Board of Directors for 1968-69. He assumed the Chair at this point.

COMMITTEE MEMBERSHIP APPOINTMENTS

STANDING COMMITTEES

Benevolent and Loan Fund Committee

Daniel T. Cloud, M.D. (Phoenix), serving for the term 1966-69, redesignated Chairman for the Year 1968-69; George Boiko, M.D. (Casa Grande) appointed for the term 1968-70; and William N. Chloupek, M.D. (Phoenix) appointed for the term 1968-71.

Executive Committee

By amendment to the By-Laws, the Executive Committee for the first time became a Standing Committee; Arthur V. Dudley, Jr., M.D., President; Richard O. Flynn, M.D., President-Elect; Fred H. Landeen, M.D., Vice President; John P. Heileman, M.D., Secretary; Philip E. Dew, M.D., Treasurer; and Arnold H. Dysterheft, M.D., Past President, (ALL AS SPECIFIED).

Governmental Services Committee

William B. Steen, M.D. (Tucson) re-appointed for the term 1968-71, and redesignated Chairman for the year 1968-69; George A. Spendlove, M.D. (Phoenix), appointed for the term 1968-71; Dale H. Stannard, M.D. (Phoenix) appointed for the term 1968-69; Glenn H. Walker, M.D. (Coolidge) appointed for the term 1968-71; David R. Minter, M.D. (Tucson) appointed for the term 1968-71; and Stephen A. Letourneaux, M.D. (Nogales) appointed for the term 1968-71.

Grievance Committee

Richard G. Hardenbrook, M.D. (Prescott) appointed for the term 1968-71; and Hermann S. Rhu, Jr., M.D. (Tucson) re-appointed for the term 1968-71. As specified, Arnold H. Dysterheft, M.D. (McNary), Past-President, will serve as Chairman for the year 1968-69.

History and Obituaries Committee

Roland F. Schoen, M.D. (Casa Grande), Editor-in-Chief (as specified) appointed for the term 1968-71, redesignated Chairman for the year 1968-69; John R. Green, M.D. (Phoenix) appointed for the term 1968-71; and John W. Kennedy, M.D. (Phoenix) re-appointed for the term 1968-71.

Industrial Relations Committee

Stanley S. Tanz, M.D. (Tucson), serving for the term 1966-69, designated Chairman for the year 1968-69; James D. Alway, Jr., M.D. (Phoenix) appointed for the term 1968-71; and William R. Myers, M.D. (Phoenix) re-appointed for the term 1968-71.

Legislative Committee

Arthur R. Nelson, M.D. (Phoenix) appointed for the term 1968-71, and designated Chairman for the year 1968-69; William J. Clemans, III, M.D. (Florence) appointed for the term 1968-71; C. Truman Davis, M.D. (Mesa) re-appointed for the term 1968-71; John P. Holbrook, M.D. (Tucson) re-appointed for the term 1968-71; John F. Kahle, M.D. (Flagstaff) appointed for the term 1968-71; and John E. Oakley, M.D. (Prescott) appointed for the term 1968-71.

Medical Economics Committee

Ian M. Chesser, M.D. (Tucson), serving the term 1967-70, redesignated Chairman for the year 1968-69; Richard S. Armstrong, M.D. (Tucson) appointed for the term 1968-69; Kenneth A. Dregseth, M.D. (Sierra Vista) appointed for the term 1968-71; Don V. Langston, M.D. (Phoenix) appointed for the term 1968-71; John H. Ricker, M.D. (Phoenix) re-appointed for the term 1968-71; and Gregory C. Smith, M.D. (Scottsdale) appointed for the term 1968-69. Harvey G. Brown, M.D. (Phoenix), serving the term 1966-69, designated Vice Chairman for the year 1968-69.

Professional Committee

William G. Payne, M.D. (Tempe), serving the term 1967-70, redesignated Chairman for the year 1968-69; Jack D. Fatheree, M.D. (Phoenix) appointed for the term 1968-71; Harold W. Kohl, Jr., M.D. (Tucson) re-appointed for the term 1968-71; Hermann S. Rhu, Jr., M.D. (Tucson) appointed for the term 1968-71; and MacDonald Wood, M.D. (Phoenix) re-appointed for the term

1968-71.

Public Relations Committee

John F. Kahle, M.D. (Flagstaff), serving for the term (1966-69, designated Chairman for the term 1968-69; Walter R. Eicher, M.D. (Chandler) appointed for the term 1968-71; Don V. Langston, M.D. (Phoenix) appointed for the term 1968-71; Jack I. Mowrey, M.D. (McNary) appointed for the term 1968-71; and William C. Scott, M.D. (Tucson) appointed for the term 1968-71.

Publishing Committee

Roland F. Schoen, M.D. (Casa Grande), Editor-in-Chief, to serve as Chairman for the year 1968-69 (AS SPECIFIED); and R. Lee Foster, M.D. (Phoenix) re-appointed for the term 1968-71.

Scientific Assembly Committee

Alan L. Gordon, M.D. (Phoenix) appointed for the term 1968-71, designated Chairman for the term 1968-69; Clifton J. Alexander, M.D. (Tucson) appointed for the term 1968-71; William E. Bishop, M.D. (Globe) appointed for the term 1968-71; Milton S. Dworin, M.D. (Tucson) appointed for the term 1968-71; Rockwell E. Jackson, M.D. (Tucson) appointed for the term 1968-70; Philip Levy, M.D. (Phoenix) appointed for the term 1968-71; Laurence M. Linkner, M.D. (Phoenix) appointed for the term 1968-71; William F. Middleton, M.D. (Phoenix) appointed for the term 1968-71; Wilfred M. Potter, M.D. (Scottsdale) appointed for the term 1968-71; John S. Welsh, M.D. (Tucson) appointed for the term 1968-69; and Reginald J. M. Zeluff, M.D. (Phoenix) re-appointed for the term 1968-71.

SPECIAL COMMITTEES

Articles of Incorporation and ByLaws Committee

Charles E. Henderson, M.D. (Phoenix) re-appointed for the term 1968-69, redesignated Chairman for the year 1968-69; Arnold H. Dysterheft, M. D. (McNary) appointed for the term 1968-69; Karl L. Meyer, M.D. (Nogales) appointed for the term 1968-69; and William B. Steen, M.D. (Tucson) appointed for the term 1968-69.

Procurement and Assignment Committee

Joseph M. Greer, M. D. (Phoenix) re-appointed for the term 1968-69, redesignated Chairman for the year 1968-69; Donald K. Buffmire, M.D. (Phoenix) appointed for the term 1968-69; Louis Hirsch, M.D. (Tucson) appointed for the term 1968-69; Elvie B. Jolley, M.D. (Bisbee) appointed for the term 1968-69; Jack I. Mowrey, M.D. (McNary) appointed for the term 1968-69; James T. O'Neil, M.D. (Casa Grande) appointed for the term 1968-69; and George H. Mertz, M.D. (Phoenix) appointed for the term 1968-69.

AD-HOC COMMITTEES

Resolution No. 6 (Therapeutic Abortion)

Hermann S. Rhu, Jr., M.D. (Tucson) re-appointed for the term 1968-69, designated Chairman for the year 1968-69; William E. Crisp, Jr., M.D. (Phoenix) re-appointed for the term 1968-69; William E. Davis, M.D. (Tucson) appointed for the term 1968-69; Frederick J. Hirsch, M.D. (Tucson) appointed for the term 1968-69; Robert R. Lacock, M.D. (Tucson) appointed for the term 1968-69; David Pent, M.D. (Phoenix) re-appointed for the term 1968-69; Herbert E. Pollock, M.D. (Tucson) appointed for the term 1968-69; Edward Sattenspiel, M.D. (Phoenix) re-appointed for the term 1968-69; and Charles E. Van Epps, M.D. (Phoenix) re-appointed for the term 1968-69.

Resolution No. 15 (Physicians on Hospital Boards)

Robert A. Price, M.D. (Phoenix) re-appointed for the term 1968-69, redesignated Chairman for the year 1968-69; Jack E. Brooks, M.D. (Phoenix) re-appointed for the term 1968-69; Melvin L. Kent, M.D. (Mesa) re-appointed for the term 1968-69; Dermont W. Melick, M.D. (Tucson) re-appointed for the term 1968-69; George H. Mertz, M.D. (Phoenix) re-appointed for the term 1968-69; and Ashton B. Taylor, M.D. (Phoenix) re-appointed for the term 1968-69.

OTHER BUSINESS

Employee Leave of Absence

It was regularly moved and unanimously carried that this Board approve a leave of absence for Paul R. Boykin.

EXECUTIVE SESSION

The Board of Directors at this point in the meeting determined to go into Executive Session.

MEETING ADJOURNED AT 5:15 P.M.

John P. Heileman, M.D.
Secretary

PUBLISHING COMMITTEE

The meeting of the Publishing Committee of The Arizona Medical Association, Inc., held Wednesday, May 15, 1968, in the Central Office of the Association, Suite 201, 4601 North Scottsdale Road, Scottsdale, Arizona, convened at 7:15 P.M., Roland F. Schoen, M.D., Editor-in-Chief, Chairman, presiding.

ROLL CALL

PRESENT: Drs. Jabczenski, Felix F.; Lorenzen, Robert F.; McGrath, William B.; Schoen, Roland F., Editor-in-Chief, Chairman; Taylor, Preston J.

STARR: Messrs. Carpenter, Robert, Executive Secretary; Robinson, Bruce E., Assistant Executive Secretary.

EXCUSED: Drs. Dudley, Jr., Arthur V., President; Flynn, Richard O., President-Elect; Foster R. Lee; Green, John R.; Heileman, John P., Secretary; Johnson, Kenneth E.

MINUTE

Approved minute of the meeting of the Publishing Committee held July 19, 1967, as printed and circulated among the members.

MEDICAL SOCIETY OF THE UNITED STATES AND MEXICO

Dr. Schoen described the meeting he had with representatives of the above named society on April 23, 1968, and reviewed Dr. James D. Nauman's letter dated 4/30/68 summarizing that meeting.

It was regularly moved and unanimously carried that:

1. Yearly subscriptions to **Arizona Medicine** would be provided to Mexican members of the society at the rate of $5.00, and upon receipt of the funds and list of names the subscriptions would be activated immediately;
2. One page each month would be provided to the president of the society for dissemination of society information; and

3. **Arizona Medicine** would print brief (¼ page) summaries of the original articles in Spanish, provided that such summaries are received by the specified deadline date.

Items two and three above are contingent upon the society's success in implementing item one.

GENERAL CRITIQUE

Content

A general discussion ensued on the content of the journal. It was pointed up that we should encourage more editorial writings for the journal. Dr. McGrath was urged to continue his contributions.

Layout

Mr. Robinson presented some suggested modifications on internal layout and design. He was instructed to implement them as time permits.

AMPAC

The use of AMPAC's "My Political Creed" was discussed. It was agreed that should AMPAC be willing to provide them on an insert basis, we would publish same in a future issue.

MEETING ADJOURNED 8:28 P.M.

John P. Heileman, M.D.
Secretary

THE ARIZONA STATE NURSES' ASSOCIATION and THE ARIZONA MEDICAL ASSOCIATION, INC. NURSE-M.D. LIAISON COMMITTEE

Meeting of the Nurse-M.D. Liaison Committee held Saturday, April 20, 1968, in the Executive Dining Room, Good Samaritan Hospital, 1033 East McDowell Road, Phoenix, Arizona, convened at 1:00 P.M., William G. Payne, M.D., Chairman pro tem, presiding.

ROLL CALL

PRESENT: Mrs. Hazel Bennett (Phoenix), Executive Director, Arizona State Nurses' Association; Mrs. Dorothy Corona (Tempe), Chairman, Committee on Program, Arizona State Nurses' Association, and Associate Professor of Nursing, Arizona State University; Mrs. Beatrice Evans (Flagstaff), Member, Board of Directors, Arizona State Nurses' Association, and Director, Northern Arizona University Program in Nursing (ADN); Miss Rosamond Gabrielson (Phoenix), President, Arizona State Nurses' Association, and Executive Director of Nursing, Good Samaritan Hospital; Sister John Richard (Tucson), Director of Nursing, St. Joseph's Hospital; Miss Betty Spaulding (Tucson), President, District #2, Arizona State Nurses Association, and Director of Nursing Department, Pima County Health Department; Boyden L. Crouch, M.D. (Phoenix), representing Dermont W. Melick, M.D., Coordinator, Regional Medical Program; Arthur V. Dudley, Jr., M.D. (Tucson), President-Elect, Arizona Medical Association; Richard O. Flynn, M.D. (Tempe), Vice President, Arizona Medical Association; William G. Payne, M.D. (Tempe), Chairman, Professional Committee, Arizona Medical Association, and Representative to Joint Committee to Study Nursing Needs and Resources; Mr. Bruce E. Robinson, Assistant Executive Secretary, Arizona Medical Assoication.

EXCUSED: James Lett, M.D., Education Director, Good Samaritan Hospital, Phoenix. (Dr. Lett has resigned from the committee as he is leaving the state.)

MINUTE PROCEDURAL MATTERS

Chairman — Secretary

It was regularly moved and unanimously carried that Dr. Payne would be the chairman for a period of one year, and that the chairmanship would be alternated between the two organizations (ASNA and ARMA) on an annual basis, with the understanding that when one organization held the chairmanship, the other organization would provide the secretary. Postage and clerical expenses would be borne by the organization represented by the secretary, while all other expenses are to be the obligation of the organization from which the representative originated.

Composition of the Committee

It was agreed that this committee would be composed of a total of twelve members, six from ASNA and six from ArMA. It was further agreed that each organization would name three members on the basis of the office held in their respective organizations to ensure top level continuity, and that three would be named by each organization on the basis of the individual's special interest in the field of R.N.-M.D. relationships. Each organization will be responsible for the expenses of its own members.

Meetings

It was agreed that meetings should be held at least quarterly. The next meeting, to be composed of those listed above, will be held at 1:00 P.M. on Saturday, July 20, 1968, in Flagstaff. Mrs. Beatrice Evans will make final arrangements.

Consultants

It was felt that the committee should have the privilege of inviting consultants, such as hospital administrators, etc., to the meetings when agenda items call for such consultation.

Minutes

All agreed that minutes for each meeting should be prepared by the secretary, but that these minutes should be considered privileged until such time as the governing bodies of each group (ASNA and ArMA) have approved them. Minutes are to be distributed to the committee members and their respective staffs.

PURPOSE OF GOALS

Prime Purpose and Goal

It was unanimously agreed that the ultimate goal of this committee's efforts is to improve patient care.

Others

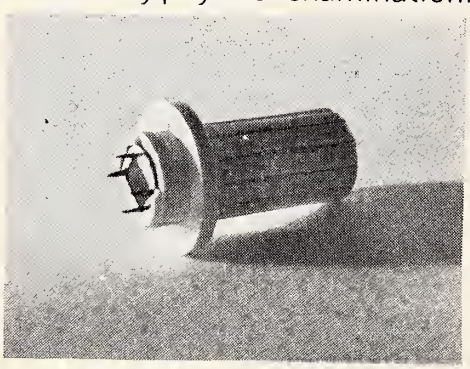
1. To establish a means for communication between the two organizations and to suggest and coordinate appropriate joint activities of the two organizations.
2. Provide a forum for identification and consideration of problems and trends related to the delivery of health services to patients and the practice of medicine and nursing.
3. To propose joint decisions of the two organizations and assist in their interpretation and implementation.
4. To consider the implications of pertinent activities, policies, resolutions, statements, etc., undertaken individually by the two organizations and assist in their evaluation and interpretation.
5. To better understand the goals and aims of nursing education programs.
6. To better understand each profession's concept of the role of the doctor, the nurse and ancillary personnel.
7. To explore the ways in which the new Regional Medical Program can be best utilized.

MEETING ADJOURNED 4:10 P.M.

William G. Payne, M.D.
Chairman

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Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
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Pantothenic Acid	15 mg

Bottles of 60

* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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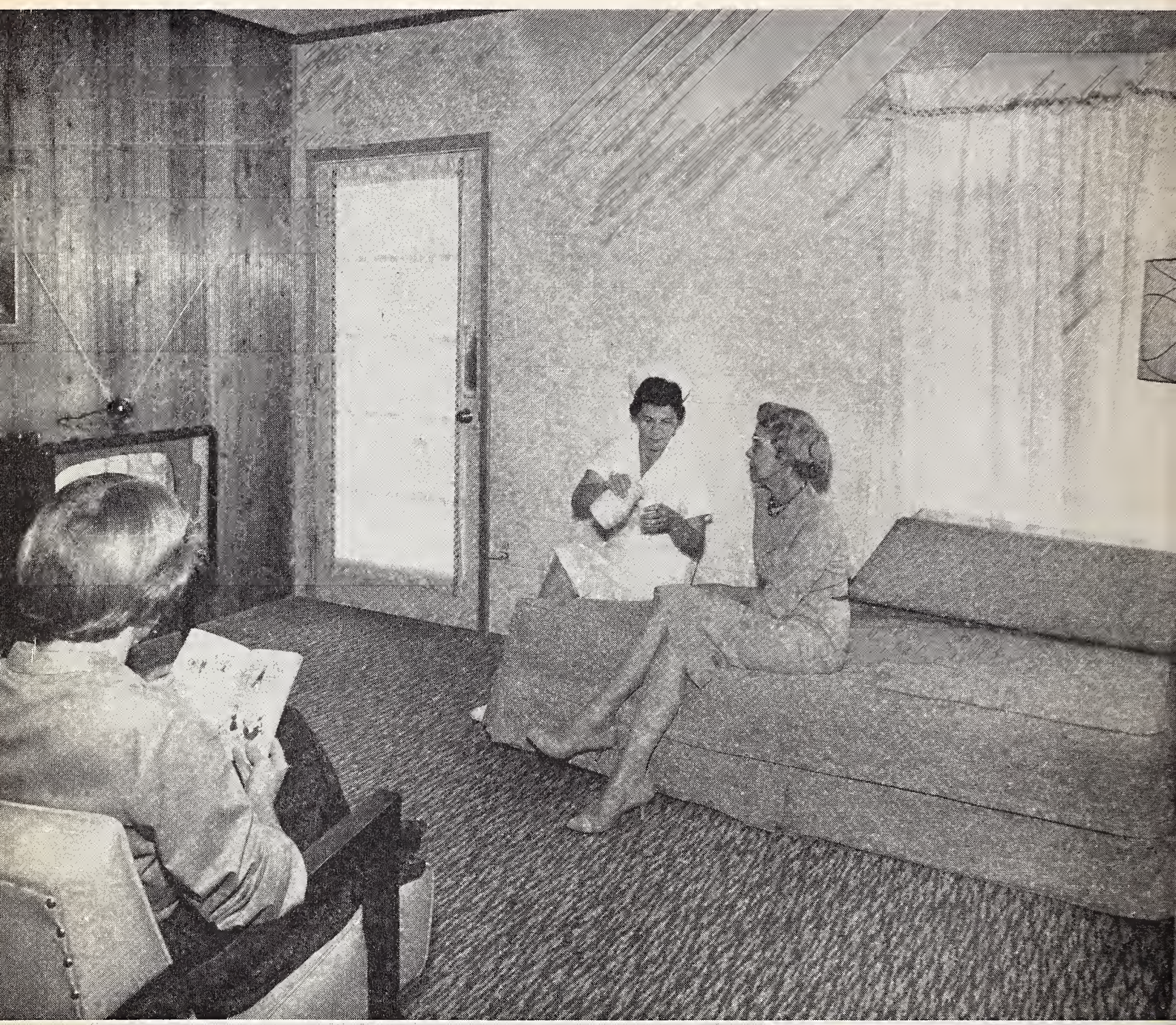
Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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ARIZONA FOUNDATION FOR NEUROLOGY AND PSYCHI
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My Political Creed

I am a free citizen in a free nation.

Whoever diminishes my freedom as an individual diminishes the sum total of freedom in my country.

I am also a physician, free thus far to treat my patients to the best of my ability.

Abridge that freedom and the health of my patients is adversely affected.

These things being true, I cannot--I will not--stand idly by when these hard-won freedoms are under attack.

For I believe that the values upon which this country was founded are immutable and have not been eroded by the passage of years.

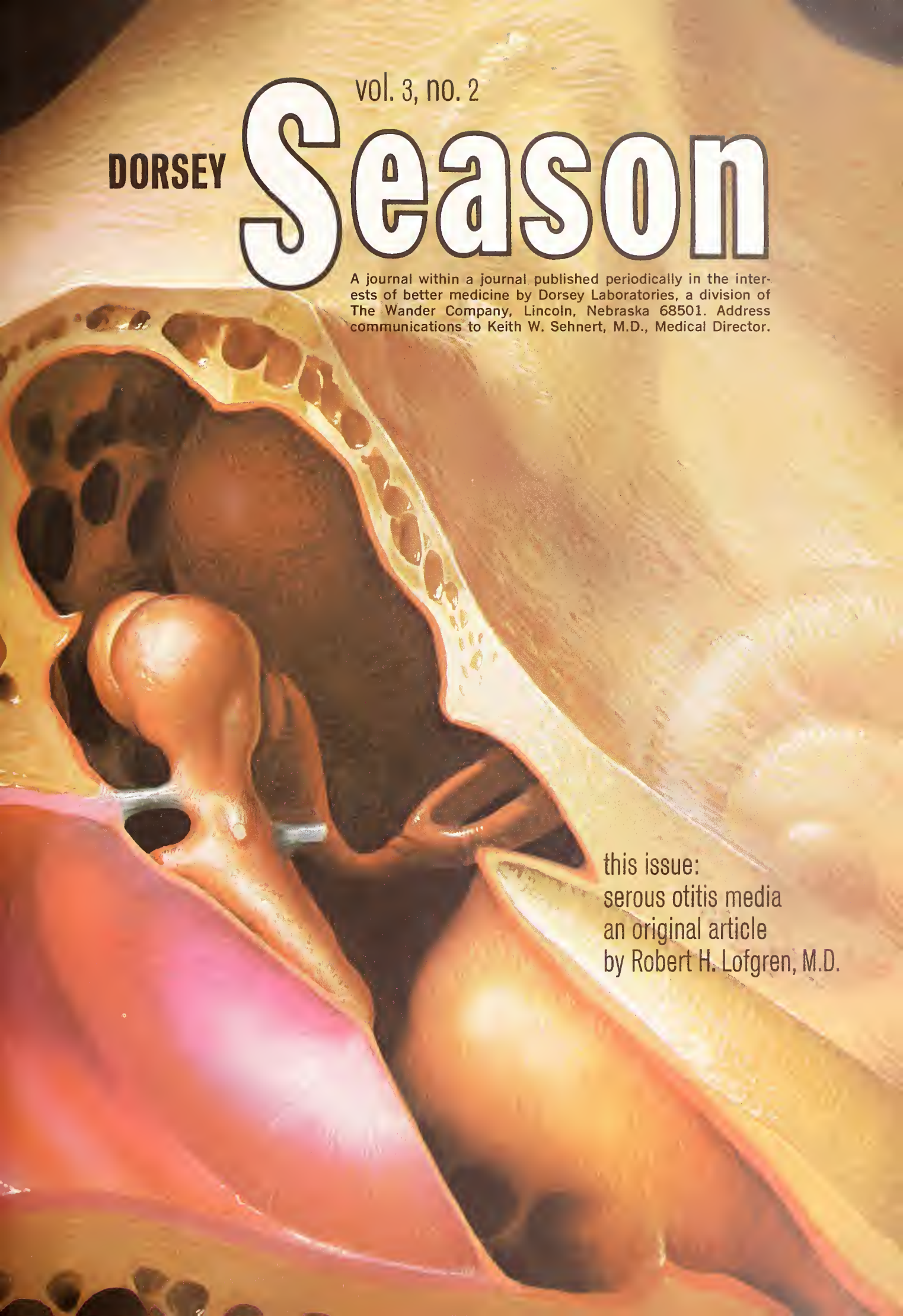
I believe that I, as a free citizen in a free land, am obligated to defend my beliefs in the ways permitted to me, and required of me, by our form of government.

Therefore, let no man seek to bar me from the political process; for it would be akin to denying my right to participate in the process that determines free government.

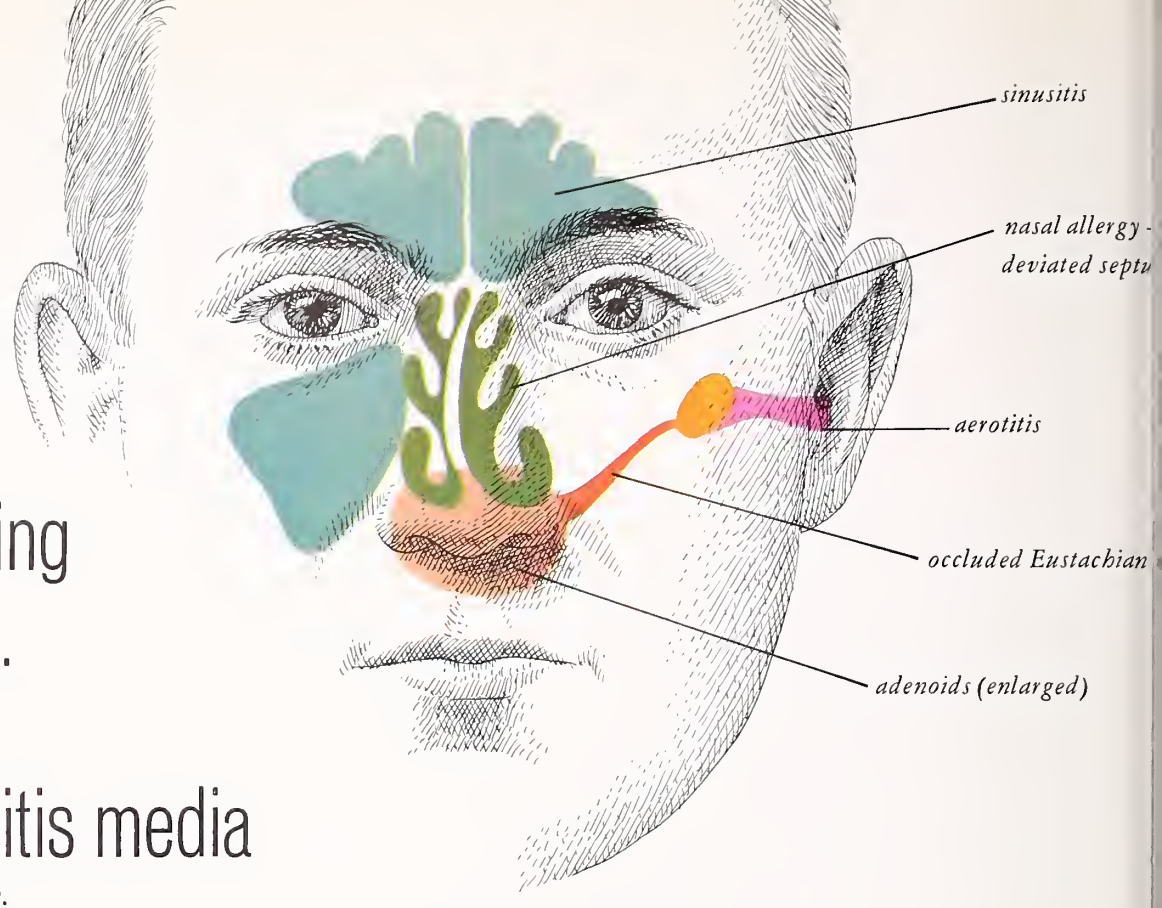
vol. 3, no. 2

DORSEY Season

A journal within a journal published periodically in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska 68501. Address communications to Keith W. Sehnert, M.D., Medical Director.



this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts

Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

The first sign of a nasopharyngeal tumor is often serous otitis. One must always rule this out in an adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been

stablished either through the eardrum or down the ustachian tube. A sterile exudate is left in the mid-lle ear.

The inflammatory response may be caused by a narked negative pressure as in air otitis from flying, r it may be from a mild bacterial or viral infection n the middle ear. Serous fluid is a good culture nedium and will frequently go on to purulent otitis nedia, especially if the original blockage was caused y an infectious process such as acute rhinitis or denoiditis. When the infection heals there may be carring in the middle ear mucosa. Mucous glands evelop in this tissue and pour out a thick mucoid naterial. This ear usually looks normal until a neumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent nd to provide drainage from the middle ear. Often nis can be accomplished by decongestants and nose rops. If large obstructing adenoids are present they hould be removed. Sinusitis should be treated with ral decongestants or nose drops, plus antibiotics here indicated. Nasopharyngeal tumors should be eated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

f the fluid does not clear with medical treatment within a week or two, a myringotomy should be lone. If there is a question of active infection or if he fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can e done in the office without anesthesia. It is no nore painful than an intravenous needle for a blood est. A good safe topical anesthetic has a tremendous psychological value to the patient. Children nder the age of 1 require no anesthesia. Between he ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to void the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the ame time as the adenoidectomy if the adenoids are nlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure nflation of the middle ear is invaluable in forcing ut the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

Otoscopic Views



Normal



Acute Serous



Acute Purulent



Chronic Serous

dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

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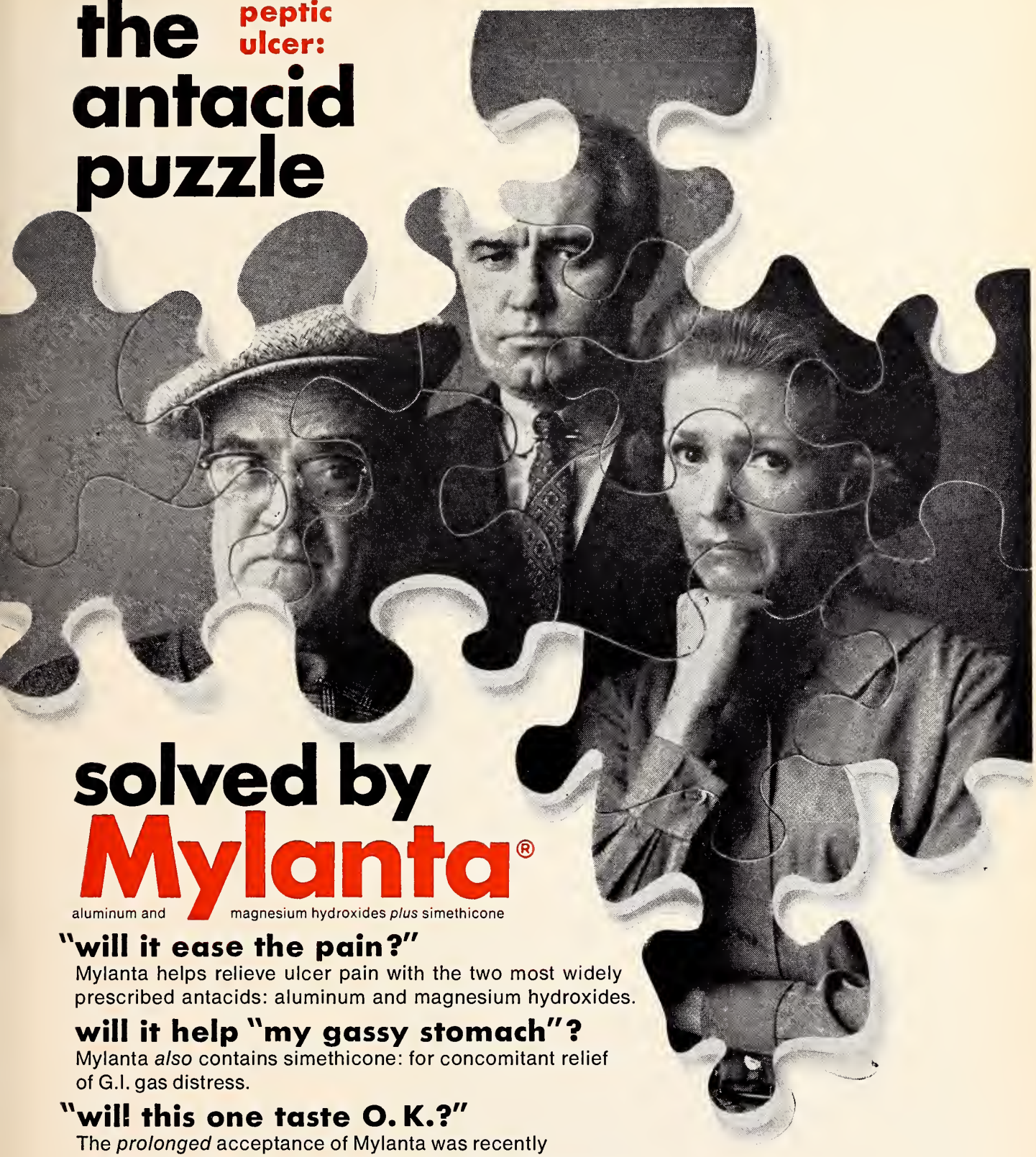
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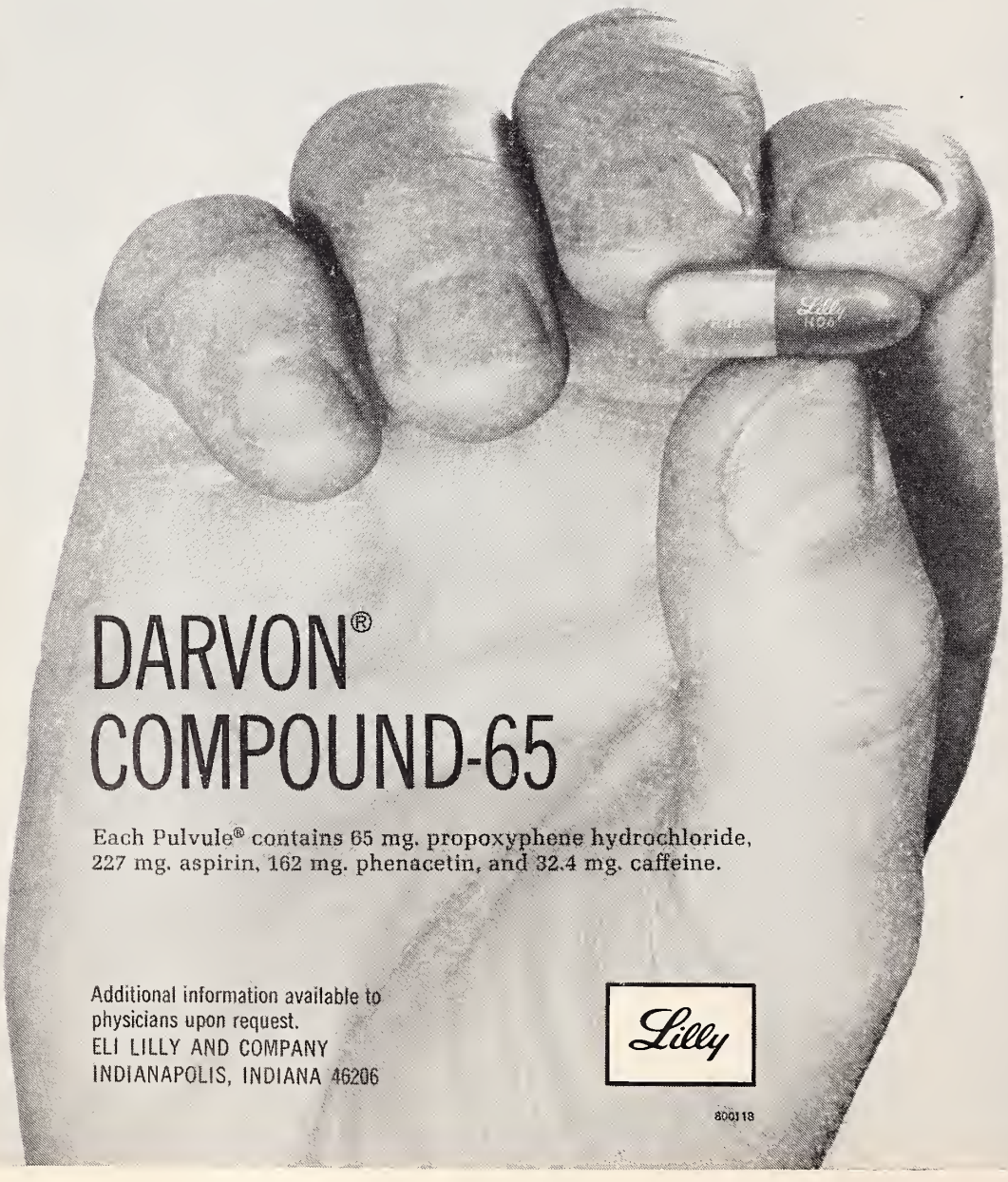
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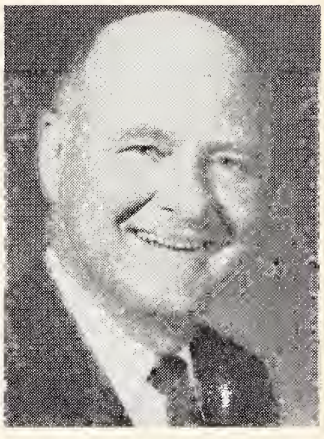
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TREATMENT OF ORBITAL CARCINOMA



James M. Ovens, M.D.

A timely appeal for prompt recognition of a curable malignancy. Attention to details of treatment and pitfalls in some are discussed by an author of considerable experience.

Introduction

Carcinoma arising in and around the orbit should be one of the earliest diagnosed of all carcinomas. The carcinoma should be diagnosed early, treated adequately, and be practically 100 per cent curable.

The treatment is at times delayed for one of two reasons:

1. The patient will delay the diagnosis, thinking he has a furuncle, sty, or other condition which he may treat with a home remedy and experience a temporary remission. He may even experience what appears to be a complete eradication of the condition, only to have it recur later. In such instances, small tumors in the earliest stage, such as basal cell carcinomas, can be treated and epithelialize over and appear to be healed, thus causing a delay in accurate diagnosis. Figure 1 represents a basal cell carcinoma of the lower lid which caused the patient to seek medical care. The small second basal cell carcinoma in the mid-third of the upper lid margin was unnoticed by the patient.

2. The delay in diagnosis may be due to the physician mistaking the lesion for another condition. However, this is not so commonly a cause of delayed treatment as is the case that many of these lesions are inadequately treated to begin with, and only when the lesion recurs is adequate treatment commenced. This is the main reason that surgical removal should always be accompanied by microscopic examination of the specimen removed and studies made of the depth and margins of the specimen, and if for any reason removal is inadequate, further teatment can be instituted immediately.

Therapy

The therapy of carcinoma arising in and around the orbit, can be individualized as far as whether or not the treatment should be by irradiation or surgery. The fact remains that

whatever treatment is used, the treatment should be adequate. Inadequate treatment by irradiation such as a low tumor dose, or too small a field, results in a recurrence as inevitably as does inadequate surgical removal of the tumor.

For practical reasons in this discussion, the therapy of the early lesions is stressed, and the therapy of advanced and recurrent lesions is only discussed briefly.

The methods of therapy to be outlined in this brief discussion, are merely suggestions of my own. They are the methods of therapy at which I have arrived with over twenty-five years of treating tumors in these parts by surgery, X-ray and radium. Other people may have good results by other methods of treatment, but the methods of treatment being discussed have been arrived at by years of trial and error, success and failure, pleasures and displeasures, adequate and inadequate excisions, adequate and inadequate dosage of irradiation, recurrent tumors, irradiation necrosis, loss of sight, cosmetic deformity and other intangible factors that now influence my choice of the therapeutic methods to be used in the treatment of these tumors.

Pathology

Carcinoma arising in the skin contained within the orbit or in the vicinity around the immediate region of the orbit, is usually basal cell carcinoma. Squamous cell carcinoma is not so common. Mixed baso-squamous carcinoma are not infrequent. Rarely malignancy arising here is a malignant melanoma or an adnexal structure tumor, which may form carcinoma, such as the hydra-adenoid carcinoma or tricho-carcinoma.

With a few exceptions, the treatment of tumors of similar size and extent is the same for either type of tumor. The exception is the malignant melanoma and its treatment is not considered in this thesis. The treatment of these is so different as to entail a separate discussion.

Deserving special mention, is a multicentrically originating basal cell carcinoma, or the "brush fire" type of basal or mixed baso-squamous carcinoma. Both of these need extra wide treatment by excision or any mode of therapy to be used (Figure 2). A pigmented basal cell carcinoma may appear grossly as a malignant melanoma, but the therapy is that of a basal cell carcinoma. (Figure 3)

Diagnosis

The ultimate diagnosis of these tumors rests



FIGURE 1



FIGURE 2
MULTI-CENTRIC BASO SQUAMOUS CARCINOMA

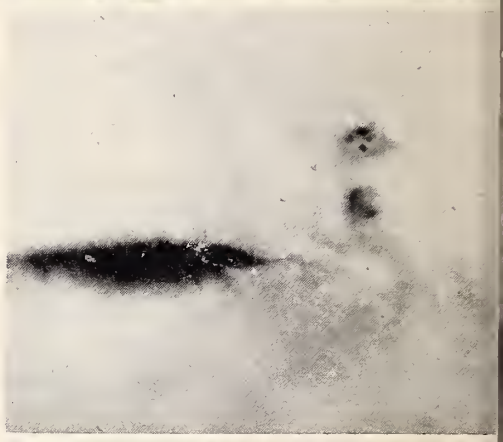


FIGURE 3
PIGMENTED BASAL CELL CARCINOMA



FIGURE 4A
SQ. CA. INVOLVING MEDIAL HALF LOWER LID AND PUNCTA LACRIMALIS



FIGURE 4B
POST THERAPY



FIGURE 5A
BASAL
CELL CA
PRE X-R-T



FIGURE 5B
POST
X-R-T



FIGURE 6A
BASAL
CELL CA.
INVOLVING
MID 2/4
UPPER LID

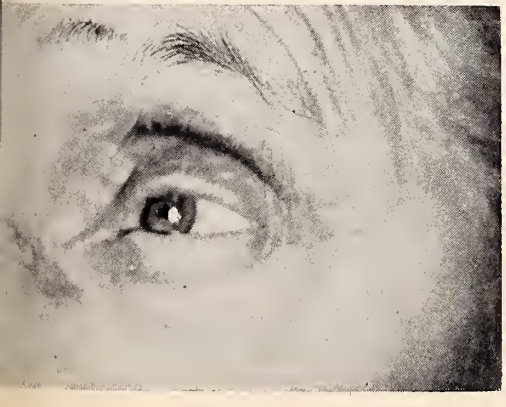


FIGURE 6B
POST
THERAPY
6 MONTHS
AFTER
THERAPY

on microscopic examination, although some are diagnosed very easily by their clinical picture. Particularly obvious are the basal cell carcinomas which occur as rounded ulcers with rolled edges, or as pearly white plaques with a firm sense to the feel, as a small button under the skin. The patient himself rarely believes he has a cancer, but usually ascribes the trouble to an ingrown hair, a sty, a pimple that has not responded properly, or to some other inflammatory process. This is true to a great extent because the patient knows about these things but does not know about cancer.

Tumors of the Lids

Carcinoma on the upper or lower lid margins, or in the region of the inner or outer canthus, in my experience, has been best treated by superficial X-ray therapy.

It is particularly important when the lacrimal puncta are involved, that the radiation should be given slowly and proper time-dosage ratio be observed to prevent stenosis of any part of the lacrimal system. Sometimes it is even necessary to keep these ducts dilated during the therapy or soon after the therapy, because at this time future strictures can be prevented (Figures 4A and B) (Figures 5A and B).

Quite frequently patients are referred who have had relatively small tumors excised, only to have the pathologist find on examination of the excised tumor, that there is tumor at the cut margin, indicating residual tumor remaining. There is not a great deal of excess tissue in the superior or inferior palpebral margin, and one frequently removes as little tissue as is possible and may leave some microscopic tumor, while the gross tumor is removed. It is for this reason that I prefer to treat upper and lower lid margin malignancies with superficial X-ray therapy Figures 6A and B). Figure 7 represents the orbital structures of a man who is diagnosed as having squamous cell carcinoma of the lower lid margin approximately 6 mm. in its widest diameter. He had surgical excision performed for this tumor. The final pathology report returned that this represented an inadequate surgical removal, with tumor on the cut margin. This necessitated superficial X-ray therapy to the entire lid including the outer canthus, where a canthotomy had been performed. The photograph is of the patient six months after completion of therapy. The conjunctivitis is due to an allergic condition. Note the loss of the entire lash

of the lower lid and outer half of the upper lid.

Care is taken to protect the eyeball by placing a specially constructed lead shield between the lids and the bulb while administering the therapy. When properly administered, not too rapidly, excellent cosmetic results can be obtained, with only the loss of the lash in the treated area as the tell-tale of therapy.

Lesions on the upper or lower lid away from the palpebral margins can frequently be excised with little or no cosmetic deformity and a cure resulting. Many of these lesions are small, round, firmly circumscribed areas with little tendency to infiltrate widely (Figure 1, lower lesions), and as such can be excised well if they are any distance from the lid margins (Figures 8A and B).

The more infiltrated lesions are best irradiated (Figures 9A and B). The ulcerated lesions that do not have rolled margins, and the lesions that appear to be multicentric in origin, should be irradiated whether on the upper or lower lids (Figure 2).

When carcinoma on the eyelids is treated by X-ray therapy, and the therapy is prolonged enough, and the proper time-dosage ratio is maintained, the dryness following, a complication of therapy in this area, is not found and is seldom complained of by the patient. Post therapy ectropion is very rare following correctly administered therapy, but is more common after surgical excision near the lower lid margins.

Advanced Carcinoma

The treatment of advanced carcinoma of the orbit and periorbital area depends on the extent of the carcinoma and the previous therapy, if any. If the patient has had no previous therapy, or if surgery alone has been done and the tumor is limited to the lids, surrounding skin and only slight invasion of the orbit, irradiation with sight preservation is still feasible. Figures 10A and B represent the pre- and post-therapy pictures of a lady with a 3 x 4 x 4 square centimeter solid basal cell carcinoma of six years duration over the gabella, previously inadequately treated and now treated with 6,000 gamma roentgens. Figure 11 represents a post-therapy photograph six months after irradiation of a biopsy proven recurrent basal cell carcinoma infiltrating along the medial aspect of the orbit and the lateral aspect of the lacrimal and ethmoidal bones, but without bulbar displacement and diplopia. The patient was treated with deep therapy using a



FIGURE 7



FIGURE 8A PRE THERAPY BASAL CELL

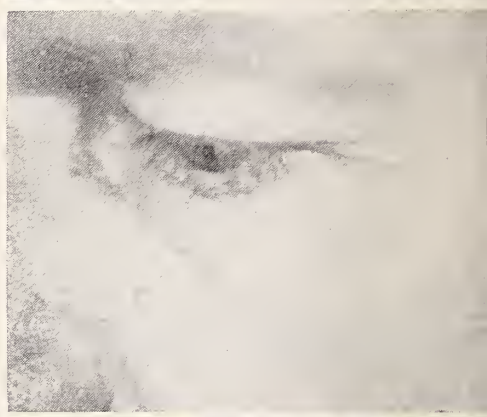


FIGURE 8B POST THERAPY BASAL CELL

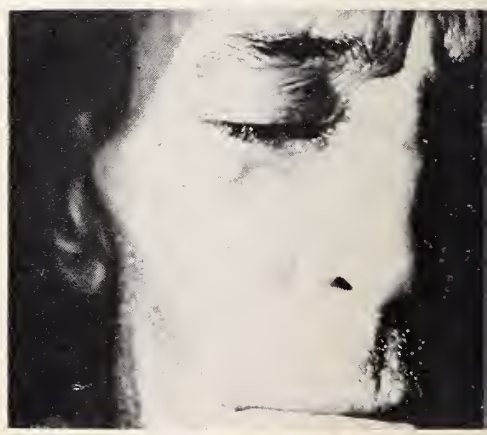


FIGURE 9A INFILTRATIVE SQ. CELL CA.

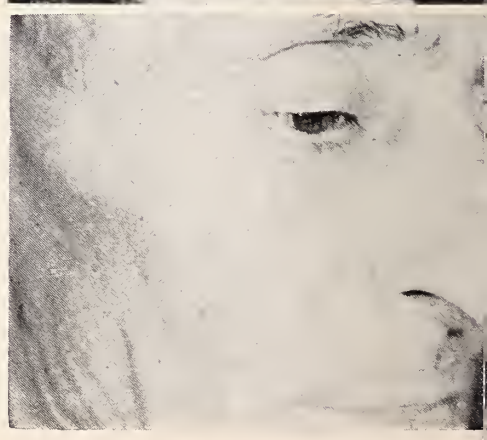


FIGURE 9B POST THERAPY

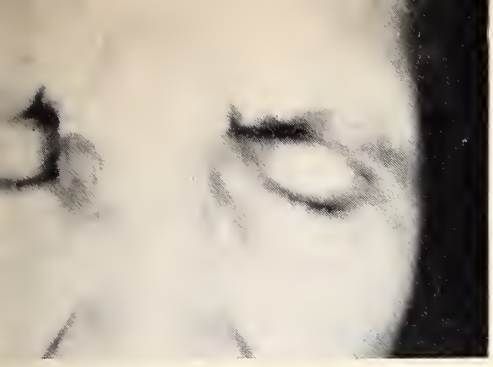


FIGURE 10A
PRE
THERAPY
BASAL
CELL CA.



FIGURE 10B
POST
THERAPY



FIGURE 11

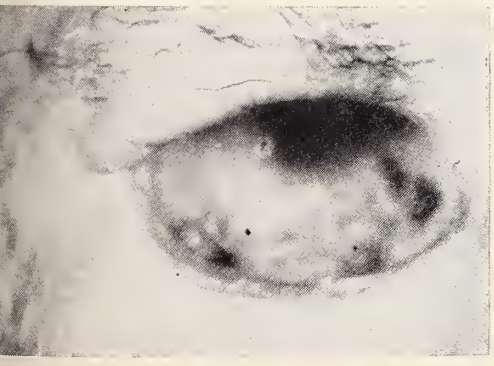


FIGURE 12



FIGURE 13
EYE
EXTENTER-
ATION

small cone and shielding the bulb well. Vision in the eye remains unaffeeted by the therapy, even though there was a dosage to the medial portion of the bulb. The tumor dosc was caluculated at 6,000+ rads. Note the loss of the lashes in the inner one-third of the lids.

In the treatment of large tumors with bulbar invasion, irradiation therapy is feasible, but the loss of sight is inevitable. In these patients, the choice between using deep X-ray therapy, interstitial radium therapy and wide surgical excision is difficult.

When bulbar displacement is present as indexed by diplopia, exophthalmia or other means on ophthalmalogical examination, radical means must be used for eradication of the carcinoma. Exenteration is the best means of therapy if bone involvement is also present. Figure 12 represents the post-therapy orbital condition of a man with a tumor invading the orbit and causing bulbar displacement and diplopia. A conservative type of exenteration was done and the orbit then grafted. It is in this group of patients in particular that the extent of the tumor and infiltration of the bulb and orbit is extremely hard to evaluate before therapy even with consultation by the ophthalmalogist. Figure 13 represents the post-operative condition of a man with extensive involvement of the bony orbit and surrounding structures by multiple basal cell carcinomas. The patient is living and well five years post-surgery.

Recurrent Lesions

The treatment of recurrent basal or squamous cell carcinoma is best carried out by deep X-ray therapy, radium needle insertion, or by wide or possibly radical surgery, depending on the previous therapy. If previous irradiation therapy has been administered, the therapy for the recurrence must be surgical, and vice versa, as a rule Such surgery may necessitate exenteration of the orbit, or even exenteration together with removal of one or more of the walls of the orbit. Figure 14A represents a recurrent neglected advanced basal eell carcinoma treated by wide resection of orbital and periorbital tumor bearing tissue. The 14B photograph shows the postoperative condition at one week, and the necessity for a cosmetic prosthesis.

Surgery is usually the preferred method of treatment, because infiltration of bone with the orbital basal cell carcinoma of any size, is a frequent occurrence. Eradication of a carcinoma in

bone is very difficult with irradiation therapy, and if the tumor is eradicated, bone necrosis may result, making surgery necessary. Post-irradiation bone necrosis is a very painful condition, and for some reason, even when the osteonecrosis has been resected, the pain in the area may persist. Figures 15 and 16 represent advanced infiltrating of orbital carcinoma involving bone, necessitating radical surgery.

When bone involvement is not present, even though the tumor is extensive, irradiation therapy may be used, but loss of vision will practically always result. Figure 17 represents a postoperative photograph ten years after surgery for a recurrent basal cell carcinoma previously treated by X-ray therapy "inadequate dosage," electrocoagulation "inadequate coagulation" and eventual exenteration of the orbit. At his last surgery, resection of the posterior orbital wall and the optic nerves as far posterior as the optic nerve decussation, along with part of the lateral and medial orbital walls, was done. The patient remained free from disease over ten years (until his death from other causes).

Regional Lymph Nodes

Regional lymph node dissection is not indicated in basal cell carcinoma therapy and is indicated in the treatment of squamous cell carcinoma of the orbit and periorbital areas only when probable or proven metastases are present. I do not believe it is indicated as a prophylactic node dissection as these lesions rarely metastasize.

Summary and Conclusions

Carcinoma arising in and around the orbit should be one of the earliest diagnosed of all carcinomas and should be treated early and adequately.

A brief outline is given of the methods that I have employed in the treatment of orbital and periorbital carcinoma over the past quarter of a century.

No matter what method of treatment is used as a primary treatment, it should be thorough and adequate.

For some reason this is not always done. We still see people who must have such radical procedures as exenteration or relatively mutilating surgery in an effort to save life, but with loss of vision in the involved eye. Even with recurrent and advanced lesions, however, occasionally the sight in the involved eye can be saved.



FIGURE 14A



FIGURE 14B

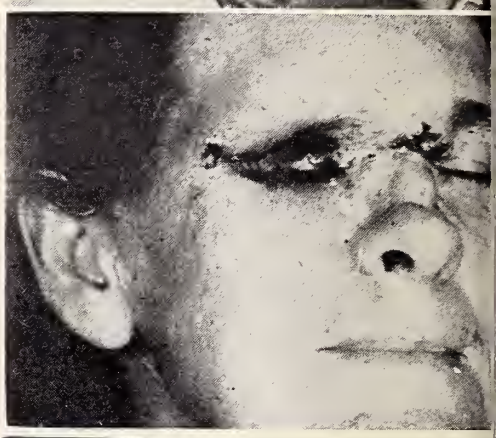


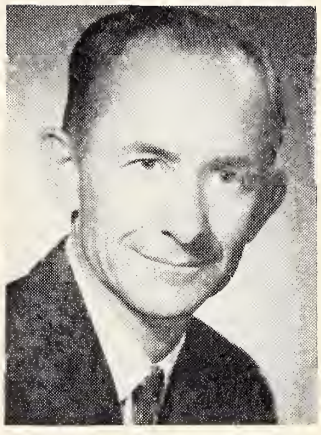
FIGURE 15



FIGURE 16



FIGURE 17
BASAL CELL CA.
POSTOP



PRESTON J. TAYLOR, M.D.

METRONIDAZOLE (FLAGYL)

A USEFUL DRUG IN AMEBIASIS

The eradication of E. histolytica from the bowel continues to present a problem to most practitioners. The use of the relatively new trichamonacide, Flagyl, holds some promise for the treatment of resistant amebic infestation.

Despite the fact that there are a number of effective drugs, the treatment of amebiasis, particularly in its chronic form, is sometimes unsatisfactory. Symptomatic improvement is inconstant and relapses are not infrequent.

Metronidazole, a nitro-imidazole derivative widely used in the treatment of trichomonas vaginitis has been shown to have antiprotozoal activity against E. Histolytica. Powell, et al recently reported on the use of metronidazole in amebic dysentery and amebic liver abscess in 56 patients. Three dosage schedules were used: 200 mg. tid, 400 mg. tid and 800 mg. tid for 10 days. The cure rate on the two lowest dosage schedules was less than 60%, however on the 800 mg. tid schedule 22 out of 25 patients were apparently cured.

Thirteen cases of amebiasis treated with metronidazole are reported in this paper.

TABLE I

ACUTE AMEBIASIS

Case #	Age	Sex	Symptoms & Duration	Metronidazole Dosage	Side Effects	Procto Smear for Amebae 1 mo. after Rx	Purged Stool for Amebae 3 mo. after Rx
1	26	M	Severe diarrhea, cramps, 3 days	500 mg. tid 10 days	None	Negative	Negative
2	17	M	Fever, bloody diarrhea, 5 days	500 mg. tid 10 days	Headache, Dizziness	Negative	Negative
3	38	F	Fever, abdominal cramps, diarrhea 7 days.	500 mg. tid 10 days	None	Negative	Negative
4	42	F	Vomiting, fever diarrhea, 2 days	500 mg. tid 10 days	Anorexia, Headache, Dizziness	Negative	Negative
5	21	M	Fever, diarrhea, 3 days	500 mg. tid 10 days	Anorexia	Negative	Negative

TABLE II

CHRONIC AMEBIASIS

Case #	Age	Sex	Duration of Symptoms	Metronidazole Dosage	Side Effects	Previous Treatment	Procto Smear 1 mo. after Rx	Stool Smear 3 mo. after Rx
1	39	M	17 months	750 mg. tid 10 days	Weakness, Nausea	Diodoquin 21 days	Negative	Negative
2	52	F	2 years	750 mg. tid 10 days	Headache, dry mouth	Milibis with Aralen - 14 days	Negative	Negative
3	44	F	15 months	750 mg. tid 10 days	None	Diodoquin 21 days	Negative	Negative
4	56	M	10 months	500 mg. tid 10 days	None	None	Negative	Positive *
5	32	M	20 months	750 mg. tid 10 days	Headache, Dizziness	None	Negative	Negative
6	42	F	? 3 years	750 mg. tid 10 days	Anorexia, Weakness, Headache, Nausea	Diodoquin 21 days	Positive	Positive *
7	22	M	6 months	500 mg. tid 10 days	None	None	Negative	Negative
8	29	M	13 months	750 mg. tid 10 days	None	None	Negative	Negative

* Retreated cases.

Patients and Methods

Five cases of acute amebiasis and 8 cases of chronic amebiasis were treated. In 9 cases the disease was presumably contracted in Mexico, 1 in Peru and 3 of unknown origin. Diagnosis was established by proctoscopic smear and or direct saline smear of a purged stool specimen. On the basis of the experience of Powell a dosage schedule of 500 mg. tid for 10 days was chosen for those patients with acute amebiasis or chronic amebiasis of less than 12 months duration. Patients with symptoms of over 12 months duration were treated with 750 mg. tid for 10 days.

The results of the studies in the two groups of patients are summarized in Tables 1 and 2.

Discussion

All 5 cases of acute amebiasis were presumably cured by a single 10-day course of metronidazole. Symptomatic improvement was noted within 24-48 hours and diarrhea subsided quickly without the use of antidiarrheal medications.

In the 8 cases of chronic amebiasis, 6 were successfully treated using a single 10-day course of therapy. Two cases, previously ineffectively treated using di-iodohydroxyquinoline (Diodoquin) and Glycobiarsol with chloroquin (Milibis with Aralen) responded to metronidazole. There were two patients who still harbored E. Histolytica 3 months after treatment. One was cured by another course of metronidazole using the higher dosage schedule. The other patient, a 42-year-old female, continued to show amebae despite treatment with 2 courses of metronidazole.

Despite the fact that no apparent toxicity was reported by Powell, significant side effects occurred in 8 of the 13 cases reported here. Headache, dizziness, nausea and weakness were those most often mentioned. Although toxic depression of white cells and platelets have been reported using metronidazole, no alterations in the hematocrit, white cells or platelets were noted during treatment.

Summary

Thirteen cases of amebiasis, 5 acute and 8 chronic, were treated using metronidazole. All of the acute cases and 7 of the chronic cases were successfully treated using 500-750 mgs. tid for 10 days. Only mild side effects, i.e. headache, nausea, dizziness and weakness were noted in these cases. Metronidazole (Flagyl) appears to be a useful drug in the treatment of amebiasis, in both its acute and chronic form.

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President's Page

This may seem like a silly question, but have you ever thought what a wonderful and rewarding life we physicians live? There is not one of us who daily feels that we are abused by over-demanding patients, not rewarded adequately for certain services that we perform, gripe about the massive amounts of paper work necessary to effect payment from third-party payors, are aggravated by after hour phone calls from druggists and/or patients (non-emergency), bewail the fact that we must climb out of bed in the middle of the night to respond to some type of emergency call and don't invariably tense up when we hear the phone ring or a radio page buzz. This list could be added to almost indefinitely.

The life of a physician is rewarding both financially and intellectually. We are allowed to proceed at our own pace and work as little as the current bills will allow or, in turn, as hard as our dream income may demand. All this can be done within the framework of the practice of medicine so long as we adhere to certain moral and ethical standards. Save for a crippling illness or disability we can continue to practice as long as we desire. No one can say at a given age that we must retire. Each of us dreams of that day of retirement, but if we look at our older confreres we realize that few doctors genuinely retire from active practice but merely cut back on their work load. By comparison almost all other businesses have mandatory retirement at 65 and, once retired, the business executive is no longer truly a part of his lifetime occupation. In essence he is set aside for younger men to assume his role.

With these thoughts in mind the Executive Committee and your Board of Directors of the Arizona Medical Association wrestled with a problem within the Central Office. Since the end of World War II the physician population of Arizona has climbed to a point where ArMA is now big business with a budget of over $200,000 yearly and multiple lay employees. Until this point in time no retirement policy decisions have been necessary. It has become evident that policy for today and for the future of ArMA had to be established. Following the 1968 Annual Meeting, the Board of Directors established policy that executive personnel must retire when they are 65 years old.

In 1950 the Arizona Medical Association hired its first full time Executive Secretary. At that time the entire physician population of Arizona was 609. The physician population kept pace with the population growth of Arizona and over these years we developed from a one man office to a present staff consisting of one Executive, one Assistant Executive and five assorted clerks, bookkeepers, stenographers and receptionists. Through these years our Executive has been Mr. Robert Carpenter — "Bob" to most of us and a good friend to all of us. It was with a deep sense of regret that the Board of Directors established policy whereby Bob would be retired from ArMA.

At a Board Meeting held on May twenty-sixth the Board appointed Mr. Bruce E. Robinson as Mr. Carpenter's successor. Bob will not be 65 until December 1969 and will remain in his post as the Executive Secretary, and during the ensuing eighteen months will have the opportunity to phase out the old and phase in the new so that there may be a smooth transfer of command.

Over the years most of us have met Bob personally and scores of us count him as a good friend personally and professionally. Realizing his tremendous storehouse of knowledge, the Board desires to keep Bob active in the paramedical fields of medicine. This is a man who should not be on the shelf but who can actively participate in the betterment of medicine through the paramedical fields. May I charge each of you as friends of Bob to seek out and obtain full or part-time employment for him in our growing paramedical fields? We as physicians may never face the problem of abrupt retirement at 65, but our lay employees do face this stark reality. The Board of Directors and I would appreciate hearing from any and all members of the Association in respect to opportunities within paramedical areas of medicine for Mr. Carpenter's future employment. May we hear from you.

Arthur V. Dudley, Jr., M.D.
President



THE STUDENTS' HONOR CODE

Last month, on this Page, we discussed some of the thinking behind the adoption, by our student body, of an Honor Code. It was poined out that the decision to adopt an Honor Code, as well as all of the specifics of the Code itself, was made by the student body. The Code has proven to be a workable instrument and a great source of satisfaction and pride to many of us at the College of Medicine. Because it has also created a high level of interest among some of the members of the Arizona Medical Association, the Code is reproduced here in its entirety.

THE HONOR CODE

The Honor Code requires that a man or woman shall act honorably in all the relations and phases of the student's medical education. Lying, cheating, stealing, or breaking one's word of honor are considered violations of the Honor Code. The result in cases of conviction will always be dismissal from the College of Medicine. A student's word of honor, once given, is inviolate, and its use in regulating trivialities is highly dangerous. The Honor Code requires that, when a student has personal knowledge of another student in suspicious circumstances and feels that the student's actions may constitute a breach of this Honor Code, he shall investigate the matter as secretly and as speedily as possible. It is not only imperative but is the very essence of this Honor Code that each and every student recognize this duty of upholding the honor of the student body and the medical profession. Any student who knowingly fails to fulfill the aforesaid duty of investigation is himself guilty of a breach of honor. Each student's obligation is to the student body and to the medical profession, even over and above that to the individual. This duty can in no way be construed as spying, talebearing, or as being in any way reprehensible. It is the finest expression of loyalty to a cherished tradition of honor among a community of self-governing students and to the medical profession. It is also important that every student should exercise the greatest care to keep himself and his fellow students free of suspicion

It is always advisable to associate two or three fellow students, if possible, in making an investigation. All materials having any connection with the case should be summarily taken possession of by the investigators, if need be against the wishes of the suspected person, as a matter of protection to all interests concerned. It is important to understand that the investigating students are the first to pass on the guilt or innocence of the suspected person. If the investigating students believe the suspected student to be guilty, they shall accuse the suspected student to his face and demand that he explain his conduct. If the investigating group is satisfied that the suspected student is not guilty of improper conduct, there shall be no further proceedings and nothing connected with the investigation shall be made public. If, after hearing his explanation or after he has refused to make an explanation, the investigating group is still convinced of his guilt, they shall forthwith notify the Honor Committee and the accused student, in writing, of the specific charges alleged against the accused student.

Upon the receipt by any member of the Honor Committee in writing of any charge against a suspected student, such member shall immediately notify the remaining members of the Honor Committee and they shall, within two days, notify in writing the accused student and the investigating group of a time, within five days, of a meeting for the preliminary determination of the propriety of the charges made

against the suspected student. This meeting shall be closed except to these enumerated persons, and there shall be no records kept at this meeting. At said meeting, the Honor Committee shall study the written charges and may hear such evidence concerning the propriety of the charges as they may desire. If four members of the Honor Committee shall, by secret ballot, vote to continue the charges over to a full hearing of the case, said Honor Committee shall thereupon notify the accused student and the investigating group of a time, not less than ten nor more than fifteen days from said preliminary meeting, for the hearing of evidence and determining the guilt or innocence of the accused; in this event, the charge may not be dropped upon the agreement of the accused to leave the College of Medicine, or for any other reason. Unless at least four members of the Honor Committee shall so vote, the charges will be quashed, and all papers in connection therewith shall be destroyed.

At the hearing of a case, minutes shall be taken by a person appointed by the Honor Committee. These minutes and all other records of the Honor Committee shall be properly stored indefinitely by the Honor Committee for safe keeping from year to year. Said minutes and records shall be kept confidential except for the members of the Honor Committee and such persons as the Honor Committee shall, for good cause, approve.

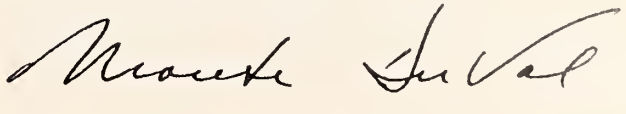
At the hearing before the Honor Committee, the investigating group and the accused may be represented by counsel from the student body of the College of Medicine, but not otherwise. Such persons or counsel shall have the privilege of examining the witnesses with relation to the facts of the case. Reasonable time shall be allowed to both sides. The accused shall be at liberty to say what he chooses in his own defense. The witnesses in the case are, of course, upon their honor to disclose truthfully all pertinent facts. The accused is presumed innocent until proven guilty by clear and convincing evidence. Said hearing shall be closed to all except the witnesses, the investigating group, the Honor Committee and their appointed secretary, and such persons as the accused may desire.

If, after hearing all the evidence and arguments of both sides, seven of the eight who compose the Honor Committee are clearly convinced of the guilt of the accused and shall so cast their votes in secret ballot, the accused must leave the College of Medicine immediately. If the accused is found guilty, the findings and the opinions of the Honor Committee shall be reported to the Dean of the College of Medicine who shall transmit all of the Honor Committee's findings and opinions to such persons as he deems advisible; it shall further be within the discretion of the Honor Committee to give such further publicity of the facts of the case resulting in a finding of guilty as shall be deemed necessary and proper. If the accused is found innocent, the Honor Committee shall report such findings to such persons or places as the accused shall reasonably request. From the decision of the Honor Committee, there shall be no appeal. A case resulting in a finding of guilty may be reopened only upon the production of new evidence bearing directly upon the question of guilt or innocence. Any persons seeking to reopen a case shall appear before the Honor Committee and state on his honor the nature of the evidence. The Honor Committee shall then consider whether the evidence is sufficiently relevant to warrant a new hearing. If a case is reopened, is shall be heard de novo.

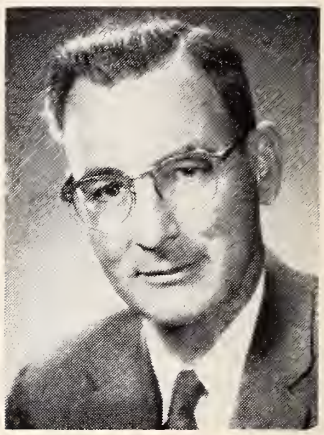
Each year, a member of the Honor Committee shall, within the first two weeks of the beginning of classes, completely read and explain this Honor Code to the entering students and to the new faculty members.

The Honor Committee represents the opinion of the students of the College of Medicine, and is not responsible to the faculty or administration as regards this Honor Code. This Honor Code shall be published in the College of Medicine bulletin and shall be included in the materials sent to the applicants to the College of Medicine.

All amendments to this Honor Code must be approved by a vote of three-fourths of the student body of the College of Medicine.



Editorial



WILLIAM B. McGRATH, M.D.

PAPIER-MACHE' PHYSICIAN

A baccalaureate nursing instructress made the rather haughty statement: "We don't train nurses; we educate them." Watch it! It is good to know the latin term, decubitus. It might be infinitely more helpful to know how to prevent or treat a bed-sore.

One of our own high-sounding cliches is to the effect that medicine is both a science and an art. All this really points out is the distinction between theory and practice. And the distinction would apply as well to journalism or banking or law or to any profession.

A common mistake is to think that we put theory into practice. No; it is the other way around. We put practice into theory. Scientific method is to observe what has already happened. Then from the experiment, from the actual experience, we induce and abstract the general statements which constitute theory. In vitro this or that antibotic stops the growth of a certain bacterial culture. This is a fact. From it we theorize that the antibiotic will cure a corresponding disease. If and only *after* it does, the information goes into the textbook.

Textbook knowledge as such is not difficult to acquire or to impart. Having almost memorized the chapter on renal failure, for example, one could give an impressive and even patronizing lecture on the subject.

But this might prove to be a papier-mache' professor, an expert only in the whitewash of words. The three-dimensional care of an actual case of renal failure is the real test, the ultimate measure of his worth. At a site of disaster we need trained surgeons, surgeons who have kept in training by constant practice. Starched theory can never afford a condescending attitude toward wrinkled old practice.

SHOULD THE FDA CONTROL MEDICAL DEVICES?

"FDA will not act arbitrarily or capriciously"

PAUL A. PUMPIAN
DIRECTOR, FDA OFFICE
OF LEGISLATIVE SERVICES

Unlike drug products, medical devices are not cleared by the Food and Drug Administration before going on the market. Only when FDA can establish in court that a device is unsafe or mislabeled can the regulatory sanctions of seizure, injunction, and prosecution be imposed.

Now before Congress is a bill giving FDA authority to clear certain medical devices before marketing. This legislation (H.R. 10726), the Medical Device Safety Act, was recommended in 1967 by President Johnson because of revolutionary advances in medical instrumentation since the original legislation was enacted in this field nearly 30 years ago.

Innovation must be encouraged. Yet, patients and physicians are entitled to the assurance that a particular device has been tested and found to be safe, reliable, and effective. This assurance cannot now be given. Instead, physicians and other health professionals must rely almost entirely on manufacturers' claims.

Formulated after many conferences between the FDA, the device industry and the scientific community, the Medical Device Safety Act is tailored specifically to the medical device area because this field is not comparable to the drug industry. Thus, when feasible, the bill authorizes standard-setting in lieu of preclearance which, itself, will diminish as standardization increases.

One fear inevitably voiced is that the extremely broad coverage of the Federal Food, Drug, and Cosmetic Act will be carried over to the pending bill. But the range of devices subject to preclearance and standardization is considerably narrower in the proposed legislation. All diagnostic instruments are exempt. All therapeutic devices which experts recognize to be safe and effective for their intended uses also are exempt from preclearance. And, finally, custom-made devices, and those under study by qualified investigators, will be exempt from preclearance as well.

The instruments that would require preclearance — unless specifically exempt — are those to be implanted in the body or placed in contact with mucous membranes for protracted periods, those delivering such forms of energy to the body as laser or ultrasound beams, and those placed in the body for communication with external equipment. For devices not covered in these categories, new data will have to be submitted for preclearance only if FDA shows probable cause to believe they are unsafe or ineffective. Use of this "special order" is very restricted, though, and so it should not be construed as bestowing broad authority on FDA.

One question which continues to plague interested parties: "Who will determine the efficacy of a device?" We admit we will have to develop our resources in this area, and consult experts in and out of government. The physician's expertise is recognized in the bill, which specifies that in pre-marketing evaluation of a device, "its safety, reliability, and effectiveness shall be determined *in the light of (its) intended use*" (emphasis added). The skill of physicians is vital in this area.

Research to be Encouraged

Of paramount importance is the question: "How will this legislation affect research with medical devices?" All devices made to doctors' specifications are exempt. Investigators may design and experiment with medical instruments unless the work is geared to support a device-clearance application (DCA). Only when research takes on commercial aspects will submissions to FDA become necessary. By using broad language in the investigatory exemption, we have attempted to insure that research efforts are not impeded. As a matter of fact, a restrictive interpretation of this section would undoubtedly be stricken down by a reviewing court.

In summary, the bill:

- exempts from preclearance purely diagnostic and veterinary devices, those made to order of physicians, those generally recognized as safe and effective — the Secretary of HEW must list these — and all those that either are already subject to a standard or for which a standard is contemplated;
- provides great latitude for research with devices, giving FDA authority to evaluate only when investigational devices enter the commercial stage;
- requires preclearance for devices used in the body or that emit certain types of energy to the body. A "special order" would be required to bring other devices under preclearance regulations;
- establishes standard-making authority over all devices that are not for diagnostic uses;
- allows the Secretary of HEW to consult outside experts in making decisions, and gives all affected parties the right to similar consultations;
- requires standards and reports from manufacturers, and authorizes both inspections and regulations to assure good manufacturing practices;
- provides for administrative and judicial appeal.

You should not feel that FDA will use the bill to act arbitrarily and capriciously. You should assume just the opposite because of the procedural safeguards and statements of intent that are built into it. This legislation provides safeguards needed to protect the public interest and does not impose unreasonable burdens on the device industry or on the scientific community.

Future Medical Meetings

THIRD SUMMER MEDICAL SEMINAR

Sponsored by the Coconino County Medical Society In conjunction with the Flagstaff Summer Festival

Saturday, August 3, 1968

Eastburn Education Building

Northern Arizona University

PROGRAM

10:00 a.m. — Premature Infant Care in Arizona
Dr. Belton Meyer, Director of Premature Infant Program, Arizona State Health Department, Phoenix

11:00 a.m. — Hematological Problems of Pregnancy
Dr. Dan Scott, Associate Professor, Obstetrics and Gynecology, Southwestern School of Medicine, Dallas, Texas

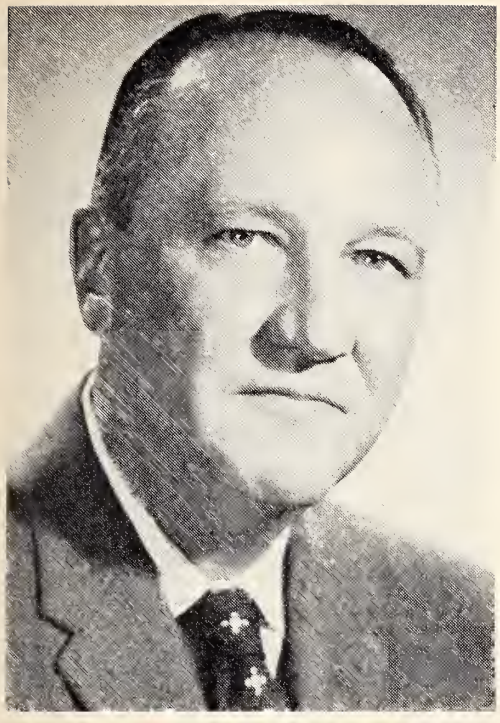
1:30 p.m. — The Modern Therapy of Thermal Burns
Dr. MacDonald Wood, Chief of Surgery, Maricopa County Hospital, Phoenix

2:30 p.m. — The Use of Long Lasting Corticosteroids
Dr. Thomas Orsmby, Associate Medical Director, Squibb & Co., New York, N. Y.

An informal dinner of Luau type will be held at the Elks Club at 6:30 p.m. Motel reservations should be made in advance.

FEE: $20.00 which includes two tickets to dinner.

Send check or money order to: Dr. D. D. Smith, Secretary, Coconino County Medical Society, 715 N. Beaver, Flagstaff, Arizona 86001



WILLIAM G. URE, M.D.
1910-1968

In Memoriam

Dr. William G. Ure, Deputy Director of Pima County Health Department, died February 15, 1968, at the age of 57. Born in Omaha, Nebraska, he received his medical education at the University of Nebraska and the University of Michigan. He served his residency at the University of Michigan 1934-1937. He came to Tucson in 1937 and was associated with the Thomas-Davis Clinic until he entered the Armed Forces in 1941.

In 1946 he entered the private practice of medicine in Tucson. In 1959 he began to work part-time as a consultant in tuberculosis for the Pima County Health Department. He worked full-time for the Tuberculosis Association during 1960 until the County Health Department took over the operation in 1961. In that year Dr. Ure joined the Department. During his seven years in that organization Dr. Ure was instrumental in bringing about a phenomenal drop in the tuberculosis rate of Pima County.

Dr. Ure was a Fellow of the American College of Physicians and of the American College of Chest Physicians, a member of the American Trudeau Society, the American Thoracic Society, the Arizona Medical Association, American Medical Association, American Tuberculosis Association and of Alpha Omega Alpha Honorary Medical Fraternity.

Dr. Ure is survived by his widow, Jeanne; three sons, William G. III, James H. and Robert F.; two daughters, Lee and Louise, and by a sister, Mrs. M. V. Henderson of Springfield, Ohio. The medical profession and the community have lost another outstanding doctor, citizen and humanitarian.

D. TERRY MOATS, M.D.
1917-1968

Doctor D. Terry Moats passed away in Good Samaritan Hospital on April sixth after a short illness. Services were held at Messinger Mortuary and burial was in his native Sherwood, Ohio.

A graduate of St. Louis University in 1943, he came here after completing his internship in Toledo, Ohio, in 1945. He has practiced for years at 1130 East McDowell Road.

Doctor Moats served in the Navy as a Lieutenant from 1944-1946. He has been a member of the American Medical Association, The Arizona Medical Association, Inc., and Maricopa County Medical Society since 1948. He is survived by his wife, June; a son, Mark; and a daughter, Paula Jo. He was a hard-working, conscientious physician and the Society will miss him.

Reprints

LANGUAGE AND THE PHYSICIAN

Lois DeBakey, Ph.D.

Students of science often have a cavalier attitude toward instruction in use of the language, which they patronizingly and mistakenly label "English grammar." They seem to consider it beneath their professional dignity to study linguistics and composition. After all, they are going to be specialists. What do they need to know about the language that they have not already absorbed? They know the lingo, the cant, the jargon that marks them as an insider. But the average medical graduate fails to realize that for four years he has lived primarily among his own professional species and has had the sympathetic eyes and ears of his teachers, who already understand the ideas he wishes to convey. Once he emerges from the cloistered walls of the medical school and hospital, however, he will have to speak in the native tongue of these who do not understand medicine — in plain English. And he cannot risk being misunderstood by them.

As the physician matures, morever, he will realize that it is important *how* he says things, and that clear, concise, forceful English is *masculine* by its very strength. When he is first obliged to write a report for admission to a professional organization or for delivery before his colleagues, he will suddenly wish that he had not considered self-expression a negligible accomplishment. He will then have to tackle alone that long-neglected aspect of his education — the effective communication of ideas in speech and writing.

For four years the medical student's reading is limited, perhaps almost exclusively, to medical publications (erroneously termed *literature*), which are marred by vagueness, repetition, monotony, ambiguity, confusion, and actual misstatement. We can hardly expect the apprentice medical writer to strive for literary excellence when the standards to which he has been exposed for four years have been far from adequate. The medical student becomes so accustomed to medicalese that he recognizes no flaws in it; he may even consider it the exclusive property of the initiated that need communicate to no one else. Rarely does he examine critically words that slip glibly from his tongue or his pen. He uses peculiar expressions without any thought of what they really mean. His statements may be so absurd that the listener must supply the intended meaning himself, as in the statements:

No tumor is hopeless unless proved otherwise.

His pelvis was fractured by being thrown from an automobile.

While passing a stomach tube, the trachea was inadvertently entered.

Often the reader or listener is left to *guess* what the intended meaning is. This becomes a crucial matter when the patient needs an interpreter

From the Department of Surgery, Tulane University School of Medicine, New Orleans.

Reprinted from the Archives of Surgery, June, 1966, Vol. 92, pp. 964-972. Copyright 1966, by American Medical Association.

to understand his physician. Despite contentions to the contrary, eogent thinkers do not always write and speak elearly, although lueid language can emanate only from an orderly, elear mind.

The language of the undergraduate medical student is almost never criticized as ambiguous or awkward or unintelligible, and rarely is he encouraged to improve his use of his native tongue. Yet the way he expresses himself affects his life probably more than any other single thing. It affects his interpersonal relations with friends, acquaintanees, colleagues, patients, superiors, subordinates — everyone with whom he comes in daily contaet. Moreover, competent self-expression is one of the most gratifying skills a person can have. It indieates to an audience something about his character, personality, and thoughts. If he expresses himself poorly, his audience will have an unfavorable impression of him; if he is articulate, his listeners will accept his ideas more readily. Even the greatest of truths, poorly communicated, remain unconvincing.

Unfortunately, the art of self-expression is left largely to chance or to one's own interest in perfecting his use of his native tongue. The inefficiency of this method is evident on examination of some publieations or attendance at some meetings. Vigorous researeh is being conducted in the precise and aecurate storage and retrieval of information by computers, but the eommunication of an idea, undistorted, from one mind to another continues to be negleeted. The only way to learn to communicate ideas accurately and intelligently is to be taught the principles and to praetice them. Not all physicians can learn to become brilliant speakers and writers, but they ean eertainly all learn to write and speak accurately and intelligently.

Medieal students and physicians, like most native speakers of English, have appallingly little understanding of the nature, history, and structure of the language, knowledge of which improves use of the language. As a result, few realize that language is a fascinating subject, even apart from its functional value. Instead, English grammar is usually taught as a hopelessly dull subject in primary and seeondary schools; teachers of presciptive grammar usually foree students to memorize unrealistie rules instead of supplying information, discussing ideas, and stimulating curiosity about the language. Little wonder that English is eonsidered insufferably boring by many students. But language is, after all, a *universal* form of social behavior and one of the most intimate possessions we have. Perhaps a few interesting observations about language will indicate its fascination and excitement.

Let us first clarify the term *language*. To the linguist, language is *speech*, and systems of writing are graphic representations of language. Writing is more standardized than speech, as evidenced by the fact that we have little difficulty interpreting the writing of an author from another part of the country or even from another English-speaking country even though his dialect may be almost unintelligible to us. For this reason, we must be more careful about our writing than our speech.

Characteristics of Language

Arbitrariness. — First, language is arbitrary, that is, there is no real, natural, or inevitable connection between an aet, an idea, or an object and the word that is used to refer to it. When we think about it, we realize the truth of this statement, but the idea that the assoeiation is real may persist in the minds of those who have not studied language seriously. You may hear someone say: "The *real* name for this is 'frying pan,' but people around here eall it a 'spider.'" Or: "Midwesterners call this 'coal oil,' but the real name is 'kerosene'." When we study a foreign language, however, we realize that the *real* word for *time* is *temps* to the French and *tiempo* to the Spanish.

But vestiges of superstition about language remain. Certain four-letter Anglo-Saxon words and certain words that refer to psysiologic bodily functions are taboo in polite society. An oath, in fact, is powerful in direct ratio to the strength of the taboo broken. In social conversations many people use such euphemisms as *pass away* to avoid the unpleasant connotation of a form of the word *death*. They say, for example, "If anything should happen to me" instead of "If I should die." And some people still knock on wood when they use certain expressions, as though to nullify the dangerous effect of the words uttered. Yet all these connections between words and ideas are solely in the minds of the people who speak the dialect or language; to a nonspeaker, they are utter nonsense.

Illogicality of Language. — A natural corollary of the arbitrariness of language is that it is *not*

logical. We cannot apply mathematical formulas to it, such as two negatives make a positive. From a linguistic standpoint, "I don't have no money" is an affirmation, and no one would interpret the double negative as a nullification. The illogicality of language is further exemplified by the fact that the present tense does not always refer to present time. It can, for example, indicate future time: "He is going to speak tomorrow," Or it can indicate past time: "I'm standing there minding my own business when this cop walks up and starts quizzing me." Or: "Charlemagne's ascension to the throne rescues Europe from her darkest hour." Or the present tense can include both the present and the past, as for example: "Jim is a medical student" or "I eat breakfast at 7:30."

Conventionality. — A second interesting feature of language is its *conventionality.* Users of a language agree to assign certain words to certain things. Without this kind of basic agreement, the primary function of language — communication — would break down.

Cultural Transmission. — A third quality of language is its *cultural transmission.* One generation passes it on to another as an acquired, not an inherited, form of behavior. At the age of six, most of us know all the grammar we need to know to form basic sentence patterns in English. We know, for example, that "The patient was very ill" communicates, whereas "Very the was patient ill" does not. From this age on, we merely extend or sharpen our use of the langauge. As with all culturally transmitted skills, people differ in their *capacities to learn.* Some never learn any more than the minimum to get through their daily activities, whereas others master the elaborate and subtle use of the language so thoroughly that it becomes their central activity. Most of us belong somewhere between these two extremes of the barely literate and the literary artist.

Functional Varieties. — Language can be divided, according to usage, into *functional varieties or levels of discourse,* ranging from the vulgate, spoken by the illiterate, to the formal, written by the highly literate. Between these two extremes are the general and the informal, which most of us use in our daily speech and casual writing. Each of these levels is functional under proper circumstances. A governmental office distributes the following memorandum: "This directive is *Restricted Information* and is to be disseminated exclusively to official administrative personnel vested with full authorization for its implementation." The dean of a medical school instructs his administrative assistant: "Send this to departmental chairmen only." And the teenager tells his cut buddy (best friend): "Don't rat this around." These all communicate efficiently and differ only in the matter of level of usage. One of the main problems in effective communication, therefore, is choice of language that is appropriate for the circumstances.

The English language is extremely complex and those who take it lightly overestimate their mastery of it. The English language is not to be found in dictionaries and grammar books; it is built into the brains of three hundred million native speakers. Dictionaries and grammar books only record certain aspects of the evolution of the language.

Grammar. — The term *grammar* has many connotations. From the point of view of the linguistic scientist, the grammar of a language is a description of the ways in which language uses *patterns of structure to convey meaning.* Descriptive formulas that grammarians derive from their study of the language are sometimes called rules or laws, and for this reason some people consider grammarians *legislators.* But they are not. The rules that they derive are like laws of nature; they are generalized formulas based on the way the language operates. To the grammarian language is a highly conventional and structured form of behavior in which orderly patterns of arrangement can be described. He recognizes, for example, that "I ain't got no dough" is just as organized and patterned as "I haven't any money." It is absurd to say that "Him and me is brothers" is bad grammar. It is, of course, unacceptable *usage* at the educated level, but it certainly communicates.

Like every language, English has its distinctive grammar; there is no universal grammar. Unfortunately, 18-century grammarians failed to realize this fact. They wanted to establish fixed standards of propriety that would *always* hold, and decided that since Latin was long the literary medium of the educated, its grammar would be an appropriate model for English. They tried, therefore, to force English into the mold

of Latin grammar. But we who use a living language refuse to be hampered by the unrealistic restrictions of a dead language. People are natural experimenters; we like novelty and change – they are a challenge to our ingenuity and inventiveness. Like food, clothing, and other aspects of human culture, our speech undergoes *continuous but imperceptible change.* If we compare Old English with Modern English, they seem like two distinct languages, and yet the language of our parents is not noticeably different from our own. Since all living languages are *continuously changing,* their grammars, which describe the way they operate, must change accordingly.

Slang. – Each generation of teenagers, for example, formulates its own distinctive slang. Today, instead of "Get off my back" you hear the teenager say "Get out of my face." When he sees a pretty girl, he says "She turns me on"; a funny comedian "cracks him up"; and if you irritate him, he may warn you: "Don't cork me off!" Teenagers make their own language, and it communicates efficiently among the initiated.

Variety of English. – Because most of us speak in frozen forms of tedious language used by the masses, we do not appreciate the *richness and variety of English.* The borrowings from foreign tongues, the inventions to label new concepts, American vigor and boldness have all enriched our language. It is true that of every hundred terms coined only one proves viable and for this reason we must be cautious about using neologisms in our writing, but coinages are interesting to observe.

Few of us realize that English contains such verbal curiosities as:

calibogus	rumblegumption
jabbernowl	skilligalee
quockerwodger	tilly-vally

Or that certain words with prefixes that suggest verbal opposites have no modern positive forms:

deceptive	repellent
disgruntled	repulsive
disgusting	uncouth
disheveled	unkempt

Our daily vocabulary contains numerous words derived from the names of interesting people and places. Consider, for example:

bowdlerize	from John Bowdler, first expurgator of Shakespeare's works
cesarean	from Julius Caesar, whose birth required a cesarean operation
calico	from Calicut, India
damask	from Damascus, Syria
duffel bag	from Duffel, Belgium
mesmerize	from Herr Doktor Mesmer, Austrian physician, who originated hypnotism
pasteurize	from Louis Pasteur, French chemist, who destroyed organisms by use of high temperatures
roentgenogram	from Wilhelm Roentgen, German physicist, who invented the x-ray machine
sandwich	from the Earl of Sandwich, noted gambler, who ate slices of meat between bread rather than stop gambling long enough to have a regular meal
shrapnel	from General Henry Shrapnel, who popularized this type of ammunition
shanghai	from Shanghai, China

Changing Meanings. – it is interesting how drastically the meanings of some words have changed through the years, at least in common usage:

	Formerly	Now
casualty	accident	victim of accident
cunning	honest skill	sly
naughty	poor	wicked
painful	painstaking	giving pain
scan	examine minutely	hurriedly glance over
silly	pitiable, weak	foolish
snob	shoemaker	prig
villain	peasant	scoundrel

Words can often be given new vigor by extension of their meaning. Poetry, of course, depends on metaphor – the transfer of a term to some object to which it is not ordinarily applicable. Many such extensions, however, applied by pseudo-intellectuals or otherwise naive persons, enjoy brief fashion and promptly disappear. I refer to such expressions as "sophisticated technic," "climate of opinion," and "publication explosion." We should, of course, be wary of using these vogue words in our writing if we value permanancy.

These few observations about our language should indicate that linguistics is an interesting science. Words are fascinating — in their derivation, their history, nuances of meaning, connotative values, and applications. Only by studying the language and by extensive reading and alert listening will you become an arbiter in your own right of what is effective and graceful. There are no magic formulas, no simple rules or easy lessons for effective communication. Proper usage, correct form, and accurate shading are all determined by the sensitivity and perception of the most talented and capable users of the language. Today, when emphasis is on placing everything within easy reach of everyone, we have the specious notion that anyone can achieve excellence. Nothing could be further from the truth. Excellence is the result of ability, effort, perseverance, discipline, sacrifice, and self-criticism. Those who have achieved it in writing and speech should serve as our models.

Standards. — The flexibility of language does not preclude standards. They may not all be hard and fast or easily defined — they will, in fact, probably be a matter of insight and sensitivity — a matter of feeling a certain unrest when you read or write something that is mediocre or inferior. The standards of scientific writing are essentially the standards of all good exposition: unity, clarity, conciseness, and logical organization and development.

Scientific writing and speeeh should be vigorous and clean. Since, however, emphasis in medical education is on *what* the student says, not *how* he says it, he speaks as successive medical graduates before him have spoken — in a tongue that is almost completely unidiomatic English, generously springkled with jargon, cliches, pedantry, repetition, overworked phrases, gobbledygook, barbarisms, and highly crystallized vocabulary. Many of these verbal eccentricities are a development of the 20th century and can probably be traced to the democratie notion of education for the masses. In medicine, we need to discard the plethora of verbal atrocities now in use, not to embrace new ones as they are thoughtlessly concocted. Physicians would do well to sharpen their linguistic tools until they are as keen as Caesar's laconic announcement on his triumphant return to Rome: "I came, I saw, I conquered," or as terse as MacArthur's trenchant pledge: "I shall return."

Jargon. — Not all jargon is bad. Technical jargon, appropriately used, is convenient and functional, but jargon, or medicalese, that results from careless use of the language is a blemish in serious medical writing and speech. Recognition that *jargon* and *gargle* have a common derivation may help us remember how distasteful it is. In surgical conferences I have heard medicalese that would offend any sensitive ear:

The patient was *carried to surgery,* and was *thoracotomized.*

Surgery is an abstract noun that refers to a branch of medicine, so a patient can hardly be carried there. Morever, since the patient was presumably transported to the operating room, the first part of the statement is superfluous. *Thoracotomized* is one of the abominable barbarisms formed by adding *-ize* to almost any noun. Note how much more directly the point can be made in three words:

Thoracotomy was done.

Cases and *patients* are often misused. You read and hear:

Six *cases* of asthma were *admitted.*

A case is an instance of a disease or a medical record, and cannot be admitted or treated: only patients can. It is hard to justify a statement like:

Physical examination *revealed* no *pathology.*

We would do well to leave the revelations to the divinity. Rarely, in fact, is it necessary to mention physical examination. The narration of the observations made will indicate that the examination was done. We need to abandon these frozen forms for relating ease histories.

You do not *operate a patient,* unless you are divine or ean manage or use the patient as if he were a machinc. Instead you *operate on* a patient. I have heard resident physicians say they *gave a patient a bottle of dextram,* as though they handed him the bottle intact. And they relate that the patient *developed* a temperature or a disease, as though it were a deliberate, willful act. Other examples of careless use of the language abound:

I contacted the hospital in the patient's home town.

This means that I made physical contact with the hospital. I suggest that use of *contact* as a verb be avoided in formal report writing. A pet peeve of mine is use of such sloppy slang as

shocky. Like *shock-like,* this word seems to be a convenient hedging device for the lazy and imprecise. Many physicians forget that the *extremities* are the head, the hands, and the feet, and that when we want to refer to the legs or arms, we should use *limbs,* not extremities.

Contradictory Expressions. — Medical speech and writing are replete with such contradictory expressions as:

just exactly similar
progressively downhill deterioration
symmetrical in size
profound rise in temperature
both maternal parents
A rare disease that is seen frequently

Humorous Expressions. — I have also heard such nonsensical, humorous, or ludicrous expressions as:

We decided to sit on the patient a while.
The patient was treated as though he were a spastic stomach.
The patient spiked a temperature.
The infant was suctioned soon after delivery.
He asked the librarian to source the material.
The patient was able to navigate.

Big Words. — I would like to hear physicians use the simple, familiar word whenever possible in preference to the pretentious or unfamiliar words. Instead of conferring erudition, pretentious words label the user as immature or factitious. None of the following big words is any better than its simpler synonym:

Pretentious	Simple
administer	give
ameliorate	improve
approximately	about
cholelithiasis	gallstones
demonstrate	show
edentulous	toothless
employ, utilize	use
endeavor	try
following	after
frequently	often
hematochezia	bloody stools
identical	same
inaugurate, initiate	begin
postoperatively	after operation
prior to	before
pyrexia	fever
sufficiently	enough
terminate	end

And none of these multisyllabic words has the power and pungency of four-letter words like:

doom	kill
fame	kiss
fear	life
fire	love
hate	rage

or even of three-letter words like:

ace	sex
ego	sin
God	war

The unwise use of big words to conceal superficial or muddled thinking too easily becomes habitual, as observed by Shakespeare in the characters of Holofernes, the village pedant, who had been "at a great feast of languages and stolen the scraps," and Armado, an affected military man who "draweth out the thread of his verbosity finer than the staple of his arguments." Disraeli described Gladstone as a "sophistical rhetorician inebriated with the exuberance of his own verbosity." When a writer knows how to handle them, of course, stiff, formal words become obedient and pliable. Some ideas cannot be expressed in simple words; in such cases appropriate longer words should be used unhesitatingly. But when an untaught person uses a big word where a little one would be better, he seems as absurd as if he were to use a steam shovel to pick up a handkerchief. Never should the desire for simplicity, however, yield to the temptation to use shoptalk like *postop, primip,* or *lab.*

The more mediocre the person, usually the greater his devotion to such high-flown words as *obfuscation, adumbration, rehabilitation, recrudescence, envisage,* and *utilization,* and the stronger his zeal for such barbarisms as *laporatomized* and *lithotomized.* So the policeman likes *inebriated* or *intoxicated;* the fireman like *conflagration* and *holocaust;* the civil service worker likes *compensation, eventuate, transmit,* and *procurement;* and the governmental official likes *implementation, effectuation, finalize,* and *commitment.*

Barbarisms. — Equally as objectionable as pretentious words are barbarisms:

Barbarism	Proper Term
alinear	nonlinear
bursted	burst
enthuse	enthusiastic
irregardless	regardless

this data	these data
this type injury	this type of injury

The following barbarisms, the result of graceless verbs being coined from equally graceless nouns, characterize hospital lingo:

Barbarism	Noun
anticoagulated	anticoagulant
digitalize	digitalis
diurese	diuresis
hemoptysized	hemoptysis
heterografted	heterograft
laparotomize	laparotomy
percussed	percussion

Redundancy. — All living languages are characterized by considerable redundancy, in the form of repetitive signals of meanings. According to communication engineers, as much as 90% of an utterance can be obliterated without eliminating its intelligibility. This explains our ability to communicate in the presence of loud noises. We need these multiple signals when we are trying to understand a foreign language. When, however, we multiply the natural redundancy in a language by adding unnecessary words that duplicate meaning, we are being inefficient, using more time and energy than are necessary. Some expressions used by physicians seem designed for the simple-minded:

adult male patient	illustrious example
audible to the ear	linear lines
basic fundamental essentials	numerous in number
black, tarry stool	potential possibility
briefly and succinctly	reason is because
cause was due to	reduplication
combine together	refer back
consensus of opinion	sour in taste
contralateral side	systolic contraction
empirical experience	therapeutic management
equal halves	thoroughly and completely
hazardous risk	tumor mass

Attributive Nouns.—Another unfortunate characteristic of the language of medicine is a lumpy series of attributive nouns that may defy extrication:

blood chemistry determinations
crisis intervention technics
human blood group B cell immune horse sera
pulmonary vein mass ligature
root nodule bacteria
total body bone survey
young coronary artery disease patient

Certain expressions in which nouns are used as adjectives have become acceptable through usage (blood pressure, brain tumor), but the tendency to amass adjectival nouns should be suppressed, not only because they are aesthetically objectionable but also because the meaning can be ambiguous, particularly to translators.

Circumlocution. — Physicians often take the long route around instead of getting directly to the point. Notice how the following circumlocutory expressions can be reduced to a single word:

Circumlocutory	Direct
adjacent to	near
as a consequence of	from
at a rapid rate	rapidly
considerable number of	many
due to the fact that	because
give rise to	cause
in the absence of	without
in the majority of cases	usually
in view of the fact that	since
juxtaposed to	next to
lateral aspect	side
vast majority of	most

Cliches. — Nothing is more devastating to speech and writing than hackneyed expressions. Cliches like the following reflect immaturity and preclude originality:

a thorough search of the literature
a valuable addition to our therapeutic armamentarium
beyond the scope of this paper
broad-spectrum antibiotic
by and large
conspicuous by its absence
in conclusion, let me say
in the final analysis
last but not least
new avenues of approach
rapidly downhill progress
serve the purpose of
suffice it to say
venture the opinion
warrants further investigation

The combination of triteness and bombast in the following passage unmistakably marks the writer as a novice:

He added his voice to the growing chorus of responsible scientists who condemned the use of phlebotomy as a panacea, and the changing tide of popularity of therapeutic blood-letting drifted quietly into oblivion to

become for the most part a relic of medicine's less sophisticated past.

Latin expressions. — Another sign of pedantry is a sprinkling of Latin expressions instead of healthy English ones. The polished speaker and writer avoids such artifice as:

Latin	English
ad lib	freely
eg	for example
et cetera	(whatever is meant)
ie	that is
in extremis	dying
modus operandi	method of procedure
per os	orally

Euphemisms. — Today, when status-seeking occupies much of our time, we find ourselves using more and more euphemisms. A bartender calls himself a mixologist, an undertaker a mortician, a hairdresser a cosmetologist, and a bookie a commission agent. In social conversation we say *nude* instead of *naked.* But words like these have no place in medicine, where it is important to call a spade by its precise name. The following common euphemisms in medicine, two of which are actually inaccurately used, should be avoided:

Euphemistic	Preferred
colored	Negro
demise	death
expired	died
respire	breathe
sacrificed	killed

Gobbledygook. — Physicians, scientists, and sociologists have an affinity for gobbledygook, a suggestive form for abuse of Formal English, characterized by wordiness, obscurity, unnecessary complexity, and often unintelligibility. They introduce numerous unnecessary, high-flown terms in the mistaken belief that inflated diction bestows elegance on speech and writings. Actually, it adds only confusion and ambiguity. Use of two or more words when one will do or use of a word of two or more syllables when a one-syllable word is just as appropriate is an indefensible extravagance. I would like to see physicians try to approach mathematical precision in their speech and writing. The medical scientific vocabulary is largely polysyllabic. Skillful medical writers and speakers, realizing that they must use a certain proportion of these, welcome one-syllable and two-syllable structures and nonscientific words whenever they can.

Unfortunately, the author does not always recognize his gobbledygook. It may creep surreptitiously into the first draft and may sound so impressive at the time of composition as to fill the author with a sense of pride. If, however, the manuscript is reread after having been set aside for a few days, the same passage may seem sophomoric and amusing. By following Samuel Johnson's advice, a writer can eliminate a great deal of gobbledygook: "Read over your composition, and whenever you meet with a passage which you think particularly fine, strike it out." Chesterton echoed the opinion of all skillful writers when he said: "To write simply is the essence of good English."

The following example of gobbledygook shows how verbosity complicates interpretation:

> In attempting to evaluate the clinical experience of others with respect to pathology and methods of treatment of carpal ganglia, considerable disparity of opinion was found and these conflicting reports motivated us to undertake a careful evaluation of our own experience, with establishment of sound criteria for cure in a statistically valid series.

Aside from the grammatical and rhetorical improprieties in this long sence, it almost defies interpretation. What do all these words mean in plain English? And what could possibly be meant by the following verbiage?

> Depending upon the quality of parental teaching and a fundamental infantile disposition to acceptance or negativism, the individual grade to maturity was a basic orientation toward either the core content of life's experiences or the peripheral context in which these experiences are embedded.

Vogue Words. — Physicians have an affinity for long, unfamiliar words and for long, indirect phrases, for abstract terms, and for expressions that are vague, ambiguous, abstruse, or evasive. Like all people, physicians are notorious mimics who seize vogue words eagerly and abuse them with overuse. Most vogue words, fortunately, go back, a bit the worse for wear, into humble obscurity after brief popularity. A few, it is true, survive the inevitable reaction against them, as, for example, *gimmick,* for which we have no

synonym. Notice how often you hear and see these vogue words, many of which are catchall terms, used, often to evade precision:

area	disadvantaged
breakthrough	escalate
broad-based	facility
climate of opinion	guidelines
heuristic approach	hard data
image	overview
in depth	parameter
knowledgeable	phased out
mainstream	realistic approach
multidimensional study	research-oriented
meaningful	sophisticated technics
new dimension	target
ongoing efforts	upgrade

We cannot, of course, change our mode of speech overnight; it is too firmly entrenched in our daily behavior. But we *can* make a start. George Orwell's comment about careless use of English I consider pertinent to the language of physicians: "One cannot change this all in a moment, but one can at least change one's own habits, and from time to time one can even, if one jeers loudly enough, send some worn-out and useless phrase — some jackboot, Achilles' heel hotbed, melting pot, acid test, veritable inferno, or other lump of verbal refuse — into the dustbin where it belongs." So scoff at your associates when they use medicalese, jargon, cliches, barbarisms, vogue words, and other verbal infelicities — and help purge medical speech and writing of some of these atrocities.

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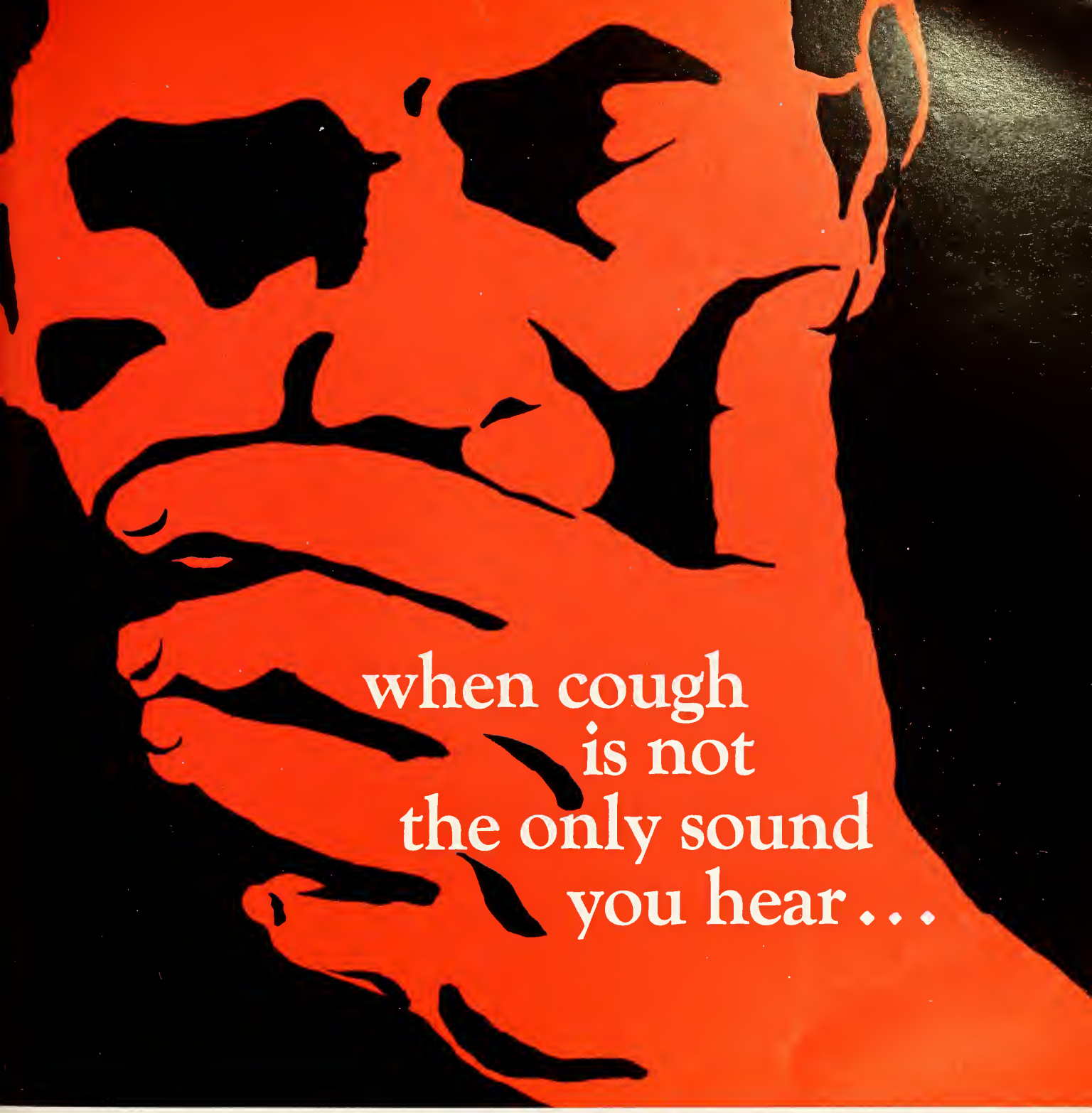
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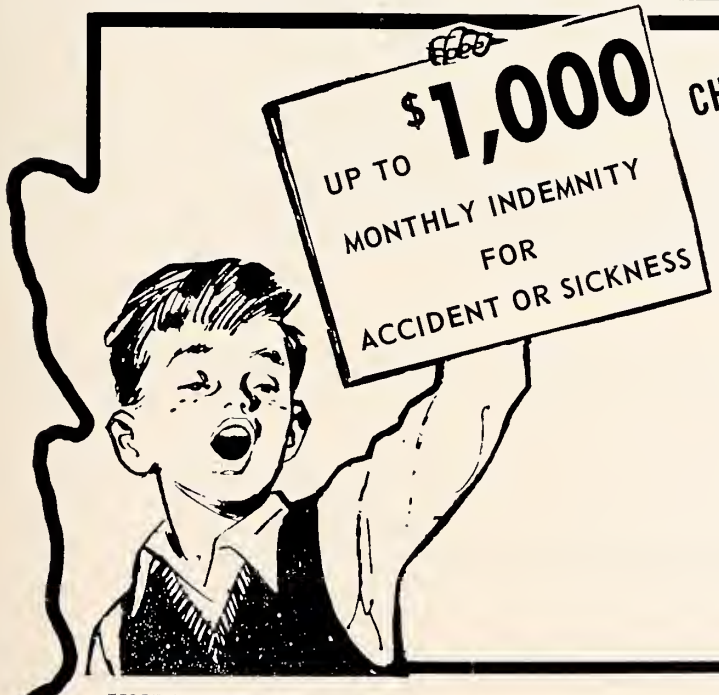
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A proposal to help you manage congestive heart failure patients:

Initiate therapy with **Hydromox*** Quinethazone 100 mg. (two 50 mg. tablets) daily for 15 days



Many patients in congestive heart failure may obtain the greatest benefit from HYDROMOX Quinethazone when it is given in a single daily a.m. dose of 100 mg. (two 50 mg. tablets). Diuresis is usually rapid and effective in reducing symptoms within the first critical days. We suggest continuing clinical evaluation over a 15-day period of therapy. If results are satisfactory, a reduction to 50 mg. (1 tablet) daily will usually be adequate for maintenance.

Precautions: Electrolyte abnormalities may be aggravated or produced. Caution is important during prolonged or intensive therapy and when salt intake is restricted. Hypokalemia has been mild and infrequent, and other electrolyte abnormalities rare. The possibility of potassium depletion and its toxic sequelae must be kept in mind, particularly in cirrhotics and patients receiving digitalis. As a preventive measure the use of foods rich in potassium, such as orange juice, may be desirable. Although not a thiazide, HYDROMOX may possess certain characteristics of the thiazides. They have been known to cause jaundice with liver involvement and pancreatitis; hematological complications such as purpura with or without thrombocytopenia and leukopenia (neutropenia); increases of serum uric acid; decreased glucose tolerance as evidenced by hyperglycemia and glycosuria thus aggravating or provoking diabetes mellitus and azotemia in patients with renal disease; photoallergy. Discontinue use a few days prior to elective surgery. When added to a regimen that includes ganglionic-blocking agents, the dosage of these latter preparations should be reduced. Also reduce dosage when one or more of these antihypertensive agents is added to an established HYDROMOX regimen. Contraindicated in anuria. Observe for possible hematologic complications.
Side Effects: Skin rash; gastrointestinal disturbances (chiefly nausea), weakness, dizziness. These seldom require cessation of therapy, and can be relieved by reducing dosage or correcting electrolyte imbalance.
Warning: Enteric coated potassium tablets have been implicated in small bowel lesions and should be used only when adequate dietary supplementation is not practical.

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To help overcome the inadequacies of poor absorption and insipid diet common in the geriatric patient—a superior, sustained-release hematinic combined with key vitamins.

Each Mol-Iron Panhemic Chronosule capsule contains: Ferrous sulfate, 390 mg. (78 mg. elemental iron) and Molybdenum sesquioxide, 6 mg. in sustained-release form; Vitamin B_{12}, 25 mcg.; Vitamin B_1, 6 mg.; Vitamin B_2, 6 mg.; Vitamin B_6, 5 mg.; Niacinamide, 30 mg.; Vitamin C, 150 mg. Supplied: bottles of 30.

*brand of sustained-release capsule

†Parsons, P.L., Withey, J.L., and Kilpatrick, G.S : Practitioner 195:656, (Nov) 1965.

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Gradual release of better tolerated, molybdenized ferrous sulfate helps assure more predictable absorption.

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Just a single Mol-Iron Panhemic Chronosule capsule daily generally corrects mild to moderate hematologic and nutritional deficiencies.





Picture of torticollis

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Paraflex® (chlorzoxazone)* 250 mg.
Tylenol® (acetaminophen) 300 mg.

Parafon Forte helps to relieve pain, restore mobility...stop pain-spasm feedback

Here is why. PARAFON FORTE provides:

a nonsalicylate analgesic equal to aspirin for the relief of pain,[1,2] yet unlikely to produce the irritation to the gastric mucosa so often associated with salicylate therapy[3]

and a skeletal muscle relaxant shown to have up to a 6-hour span of action[4]...to retain effectiveness even on continued administration[4]...but not likely to have the central effects of tranquilizing compounds.[5]

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Contraindications: Sensitivity to either component. ***Precautio***
Exercise caution in patients with known allergies or history
drug allergies. If a sensitivity reaction or signs or symptoms su
gestive of liver dysfunction are observed, the drug should
stopped. ***Adverse Reactions:*** Occasionally, drowsiness, dizzines
lightheadedness, malaise, overstimulation or gastrointestin
disturbances may be noted; rarely, allergic-type skin rashe
petechiae, ecchymoses, angioneurotic edema or anaphylact
reactions. In rare instances, *Paraflex* (chlorzoxazone) may pc
sibly have been associated with gastrointestinal bleeding. Wh
Paraflex (chlorzoxazone) and chlorzoxazone-containing pro
ucts have been suspected as being the cause of hepatic toxici
in approximately eighteen patients, it was not possible to sta
that the dysfunction was or was not drug induced. ***Usual Ad***
Dosage: Two tablets q.i.d. ***Supplied:*** Scored, light green tablet
imprinted "McNEIL"—bottles of 100.

References: 1. Batterman, R. C., and Grossman, A. J.: Fed. Proc. *14*:3
1955. 2. Goodman, L. S., and Gilman, A., ed.: The Pharmacological Basis
Therapeutics, ed. 3, New York, The Macmillan Company, 1965, p. 331. 3. Ro
J. L. A., *et al.*: Gastroenterology *44*:146, 1963. 4. Berman, H. H., *et al.*: D
Nerv. Syst. *25*:430, 1964. 5. Frier
D. G.: Clin. Pharmacol. Ther. *5*:8
1964.

*U.S PATENT NO. 2,895

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Enduron provides an excellent starting therapy. Your patient' sodium excretion is greatly enhanced. Yet potassium loss is low

The therapeutic action is smooth, and persists for a full 24 hours With Enduron you can prescribe convenient once-a-day dosag without skimping your patients on day-long thiazide effectiveness

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Use Enduron as a basic therapy in patients with mild to moc erate hypertension. A single 5-mg. tablet each day is ample i most cases.

Once a day, every day

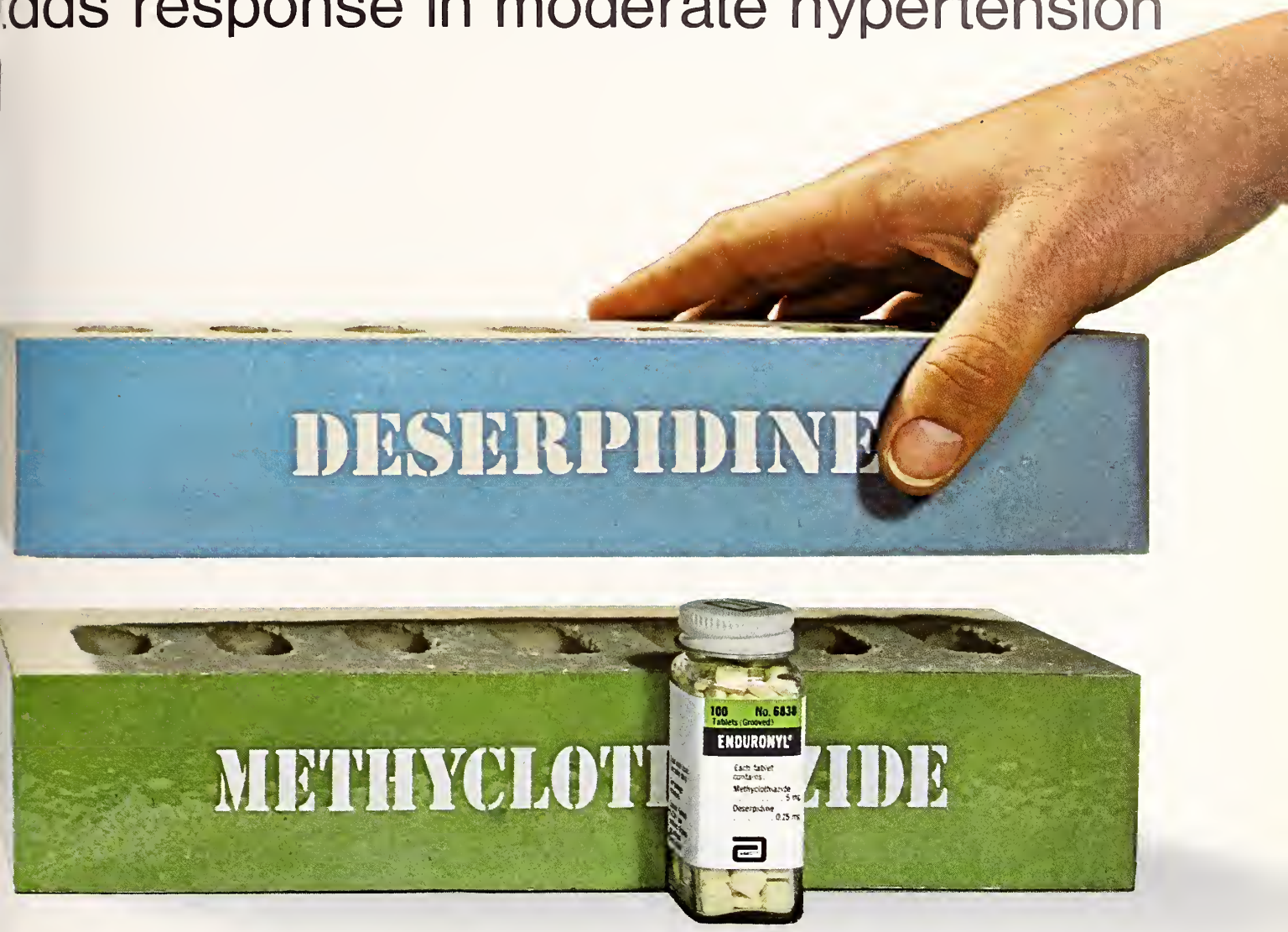
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METHYCLOTHIAZIDE



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:nduronyl: Its deserpidine component :dds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

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Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

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THYCLOTHIAZIDE 5 mg. with
SERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

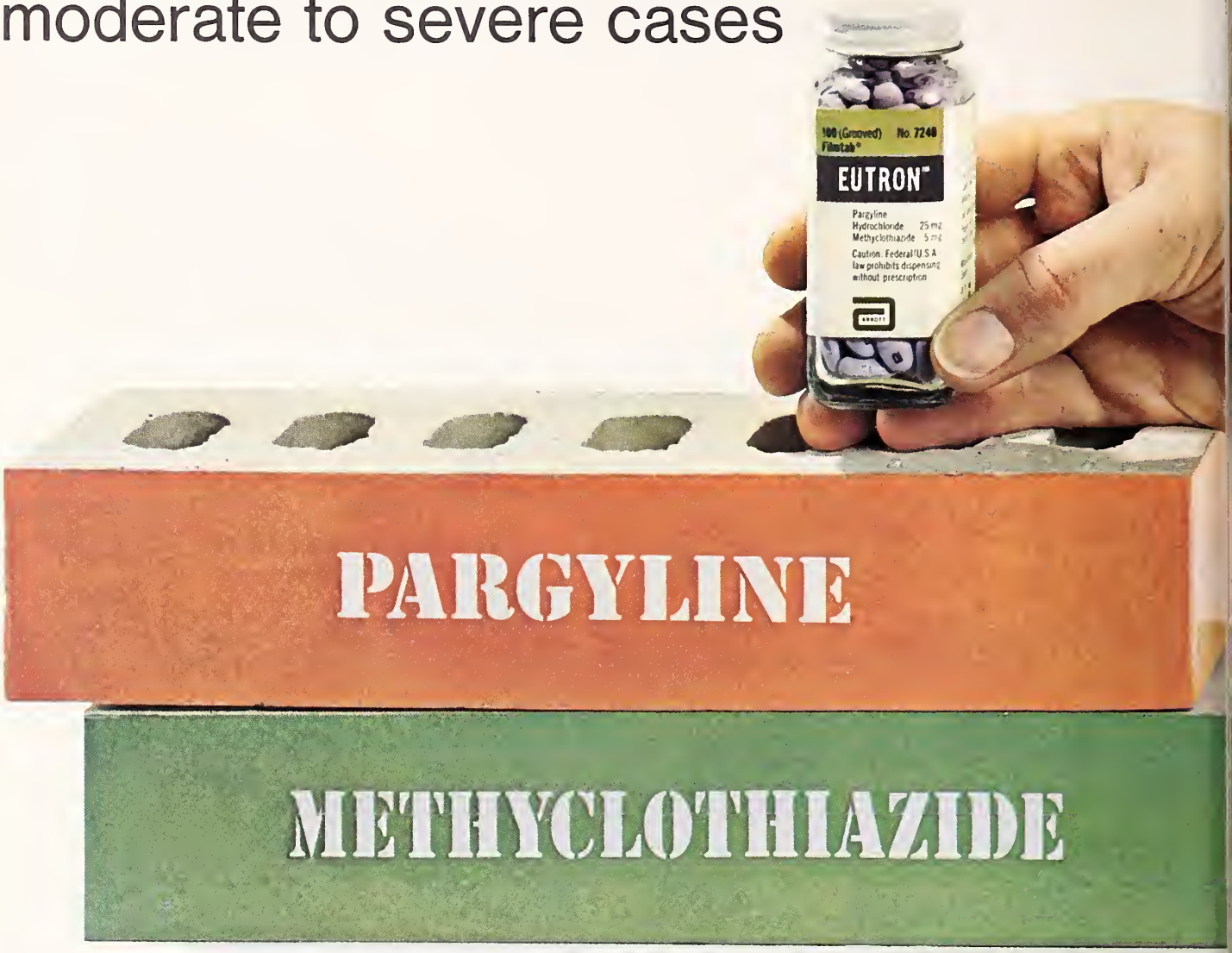
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Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

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with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

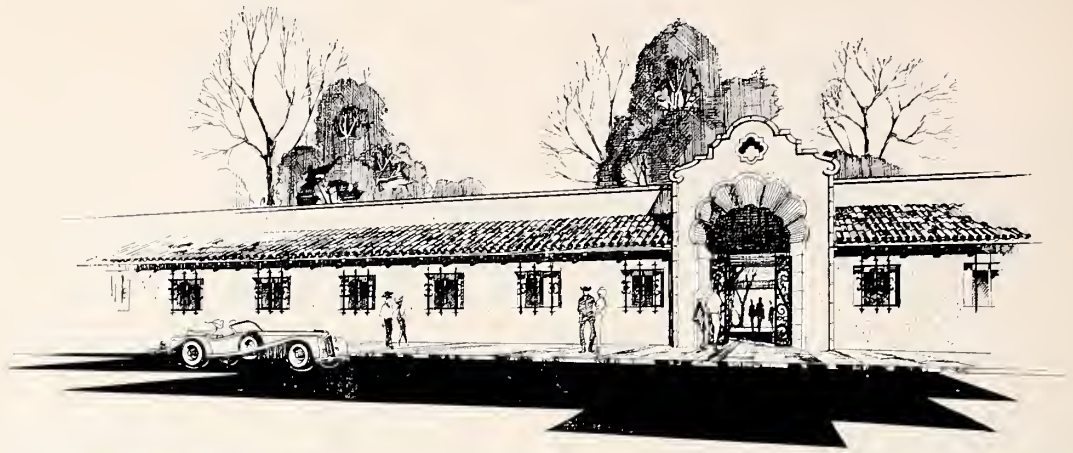
Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804439R

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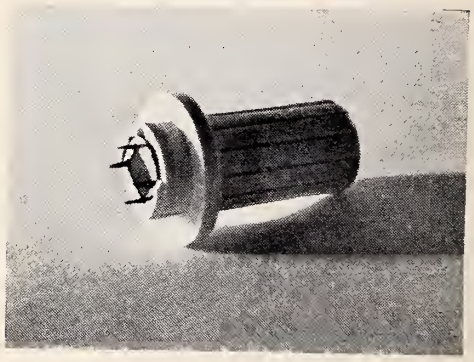
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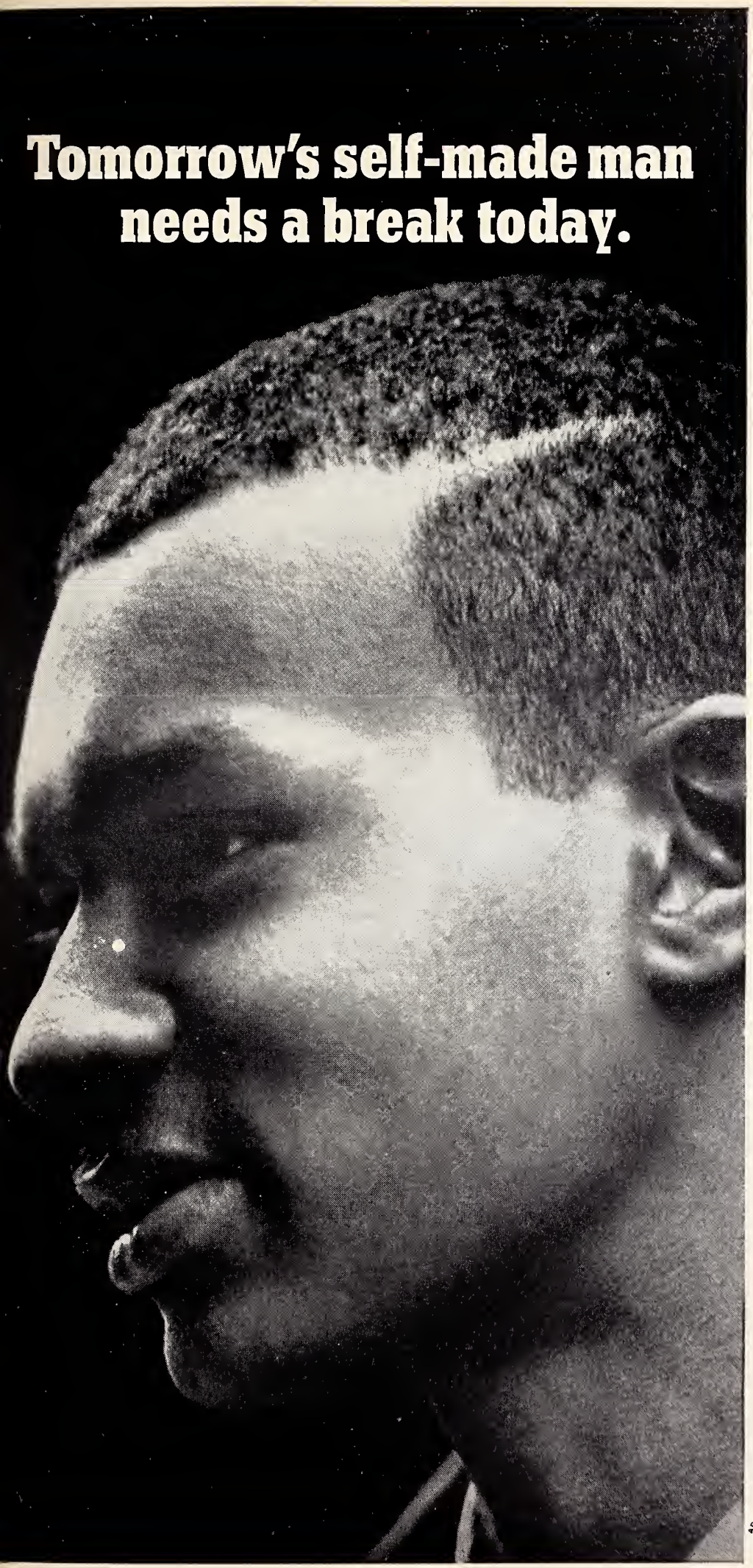
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Hire one young man or woman. Hire more if you can. But, at least hire one.

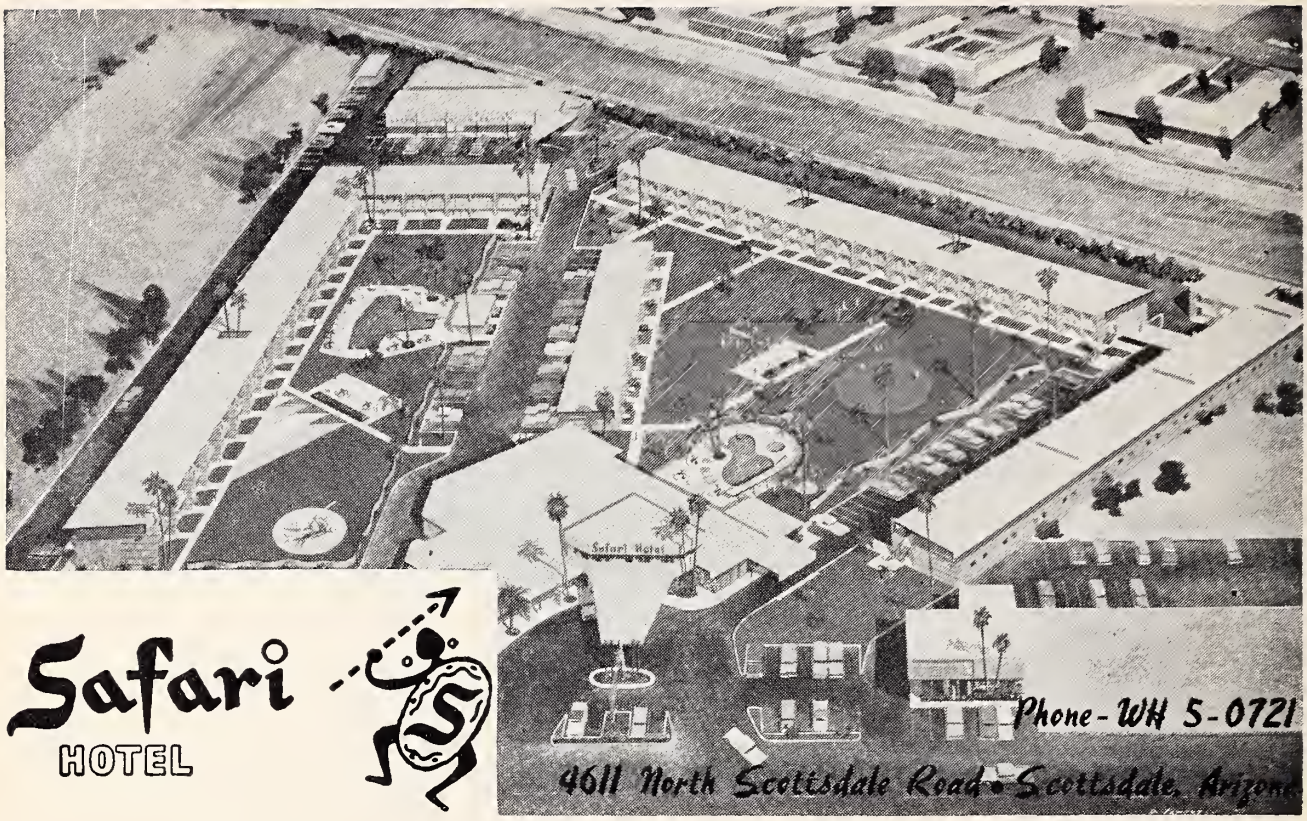
No business is too small to help. Think about an extra pair of hands for the summer. Think about a bright youngster filling in vacation gaps. Think about next summer—and the one after that—when you'll have an "experienced beginner" to call on for extra help.

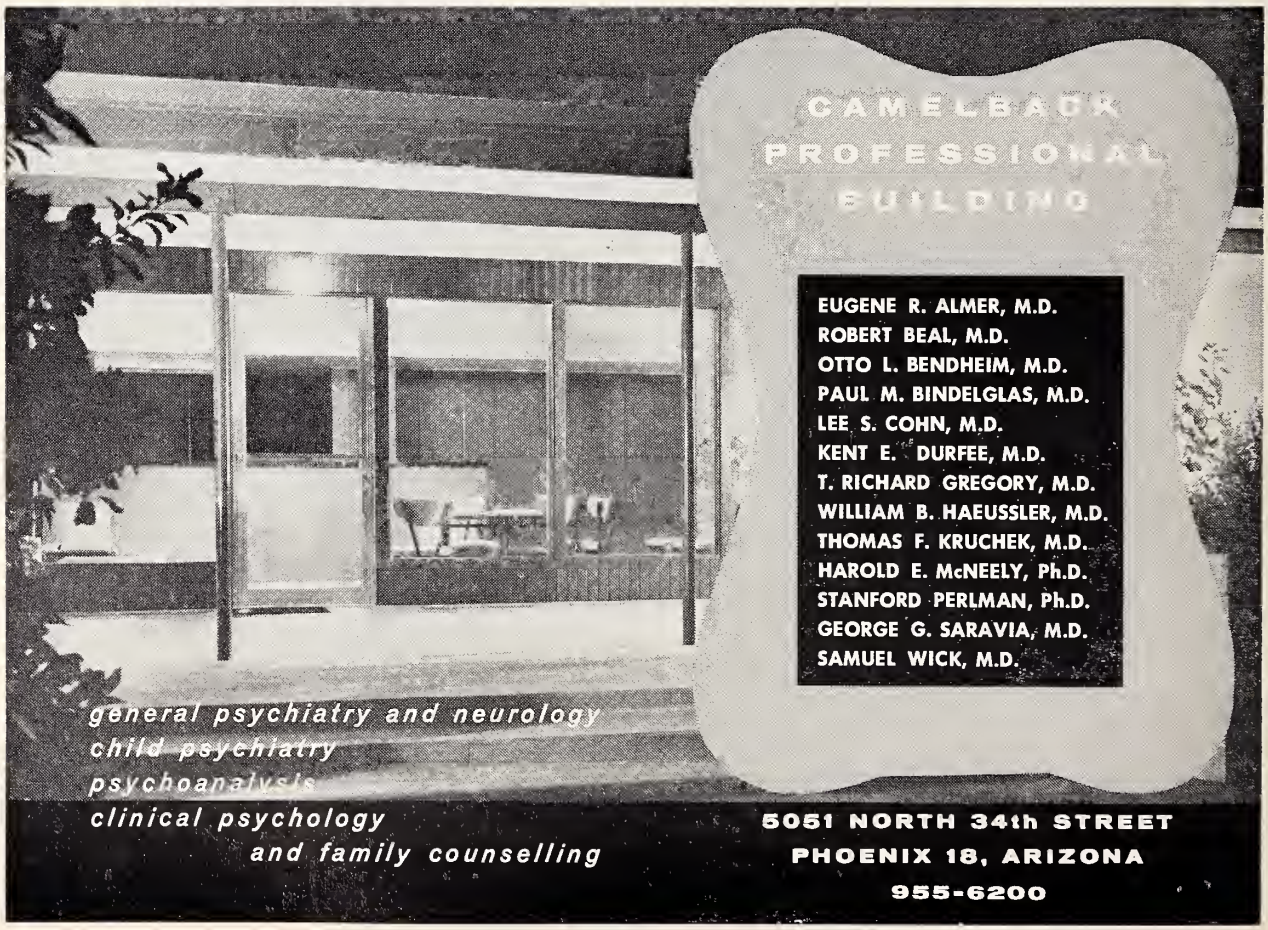
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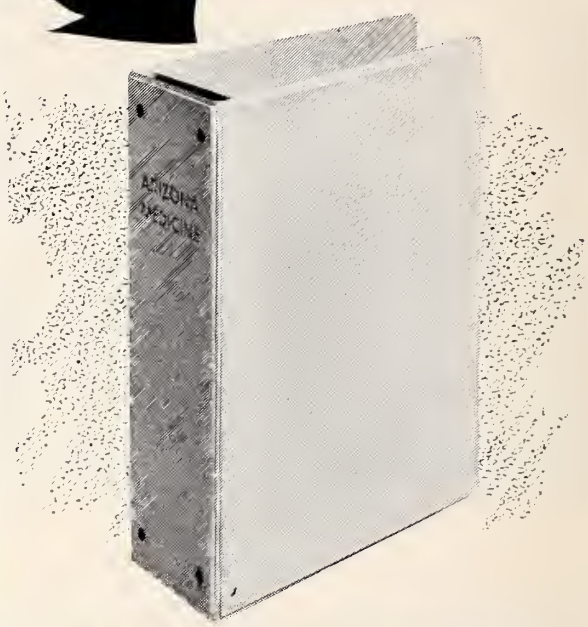
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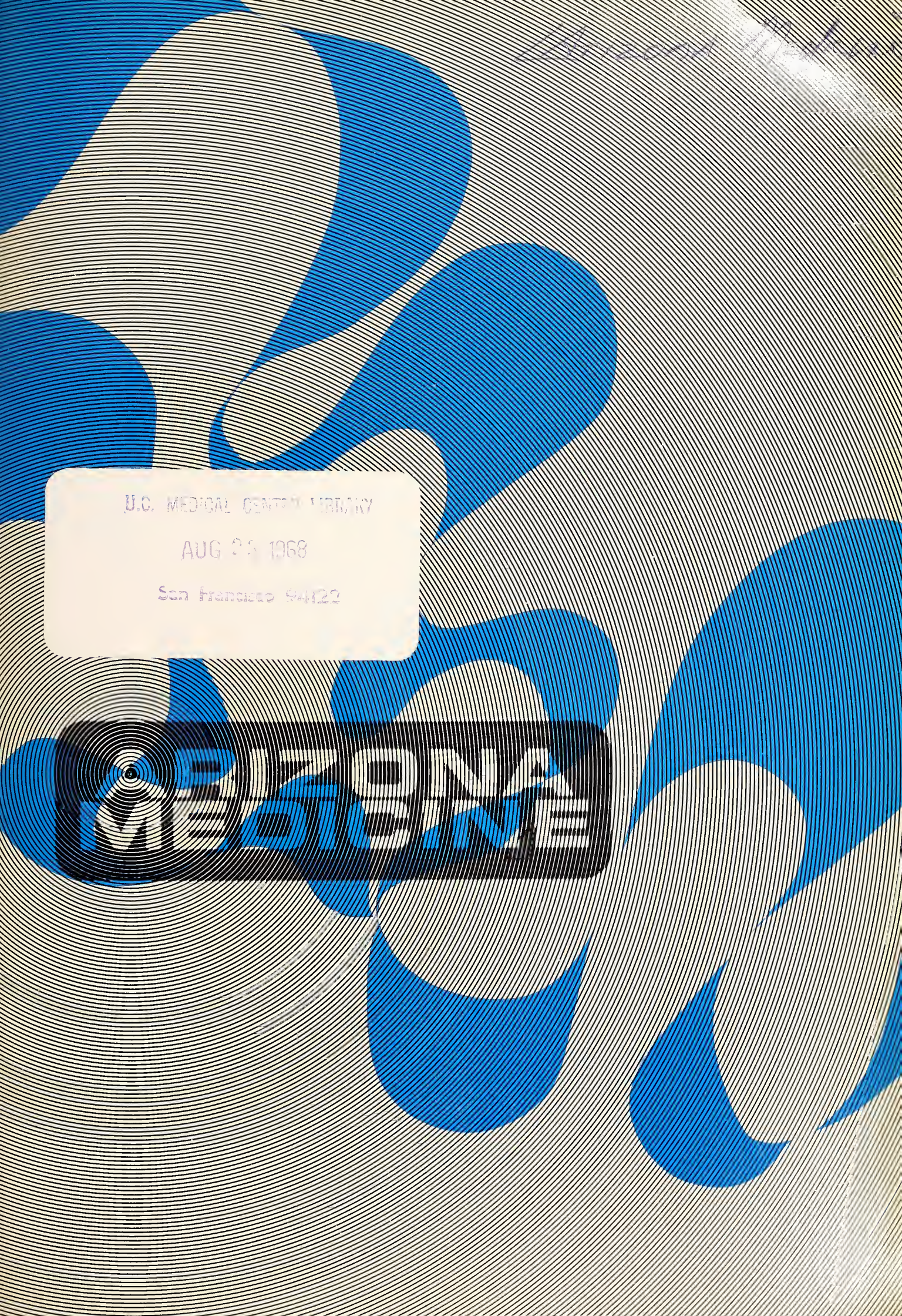
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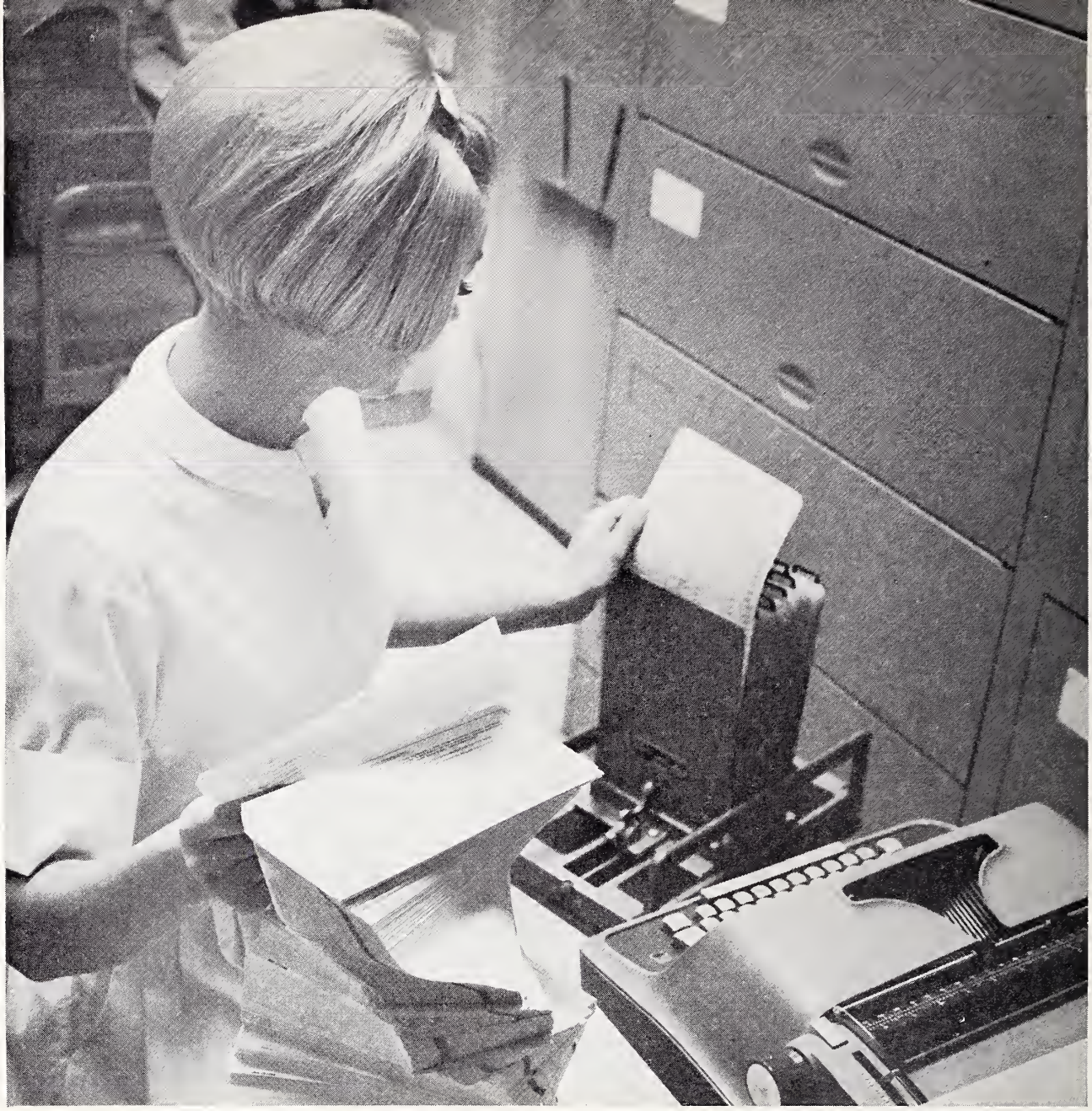
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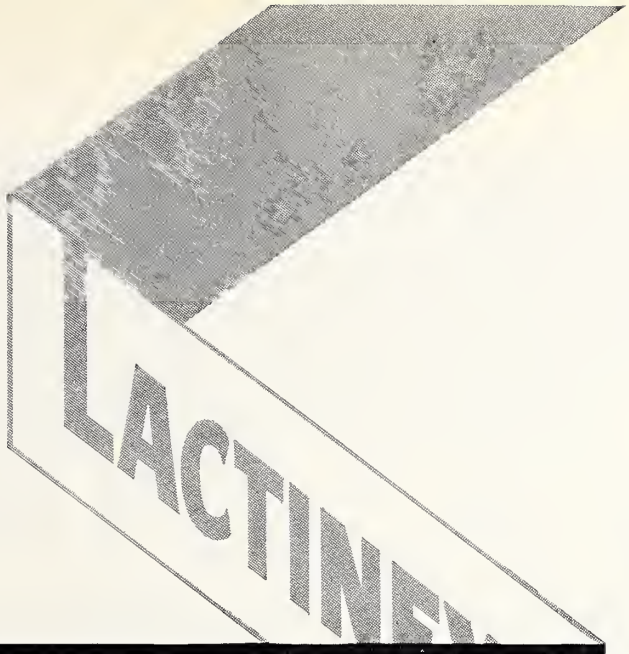
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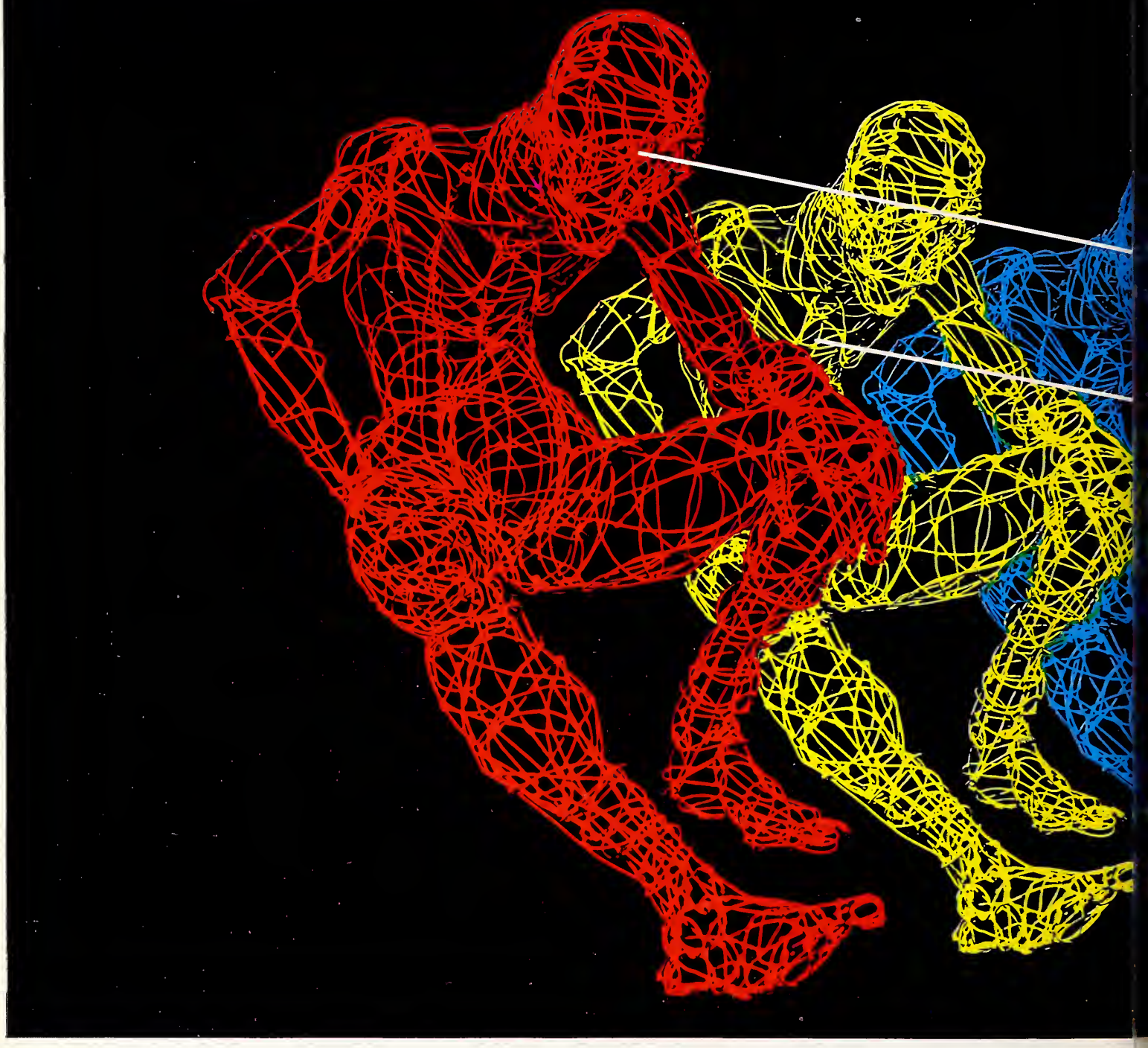
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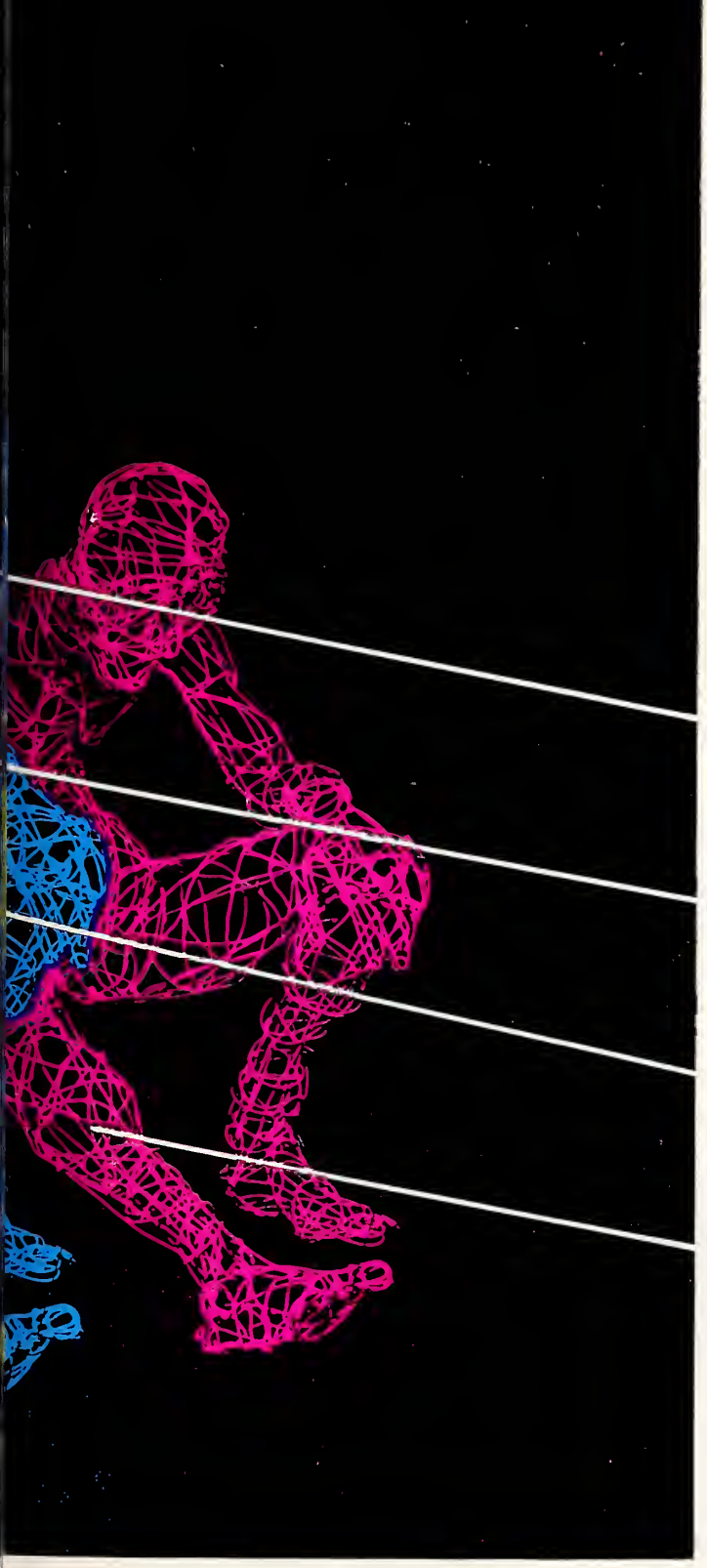
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Editor's Page

THE M.A.D. WORLD

Seniors graduating from any institution at any educational level are usually able to somewhat amaze more complacent adults. We were recently amazed upon three separate occasions.

1. A "trip" induced by the injection of meat tenderizer; recovery — but it was close.

2. An attempted "trip" by smoking banana peels — someone told him this was "grass" — it was, but it wasn't marijuana.

3. A "trip" by "popping" twenty of his mother's weight reducing Amphetamine capsules — a first trip and it was a dandy!

The M.A.D. world. The Mind Altering Drug world. Yet most of us use about three socially accepted mind altering drugs daily — caffein in our coffee; nicotine in our tobacco; and alcohol in our cocktails. Does this make us addicts? It is conceivable that we might be classified as addicted to the three above mentioned "drugs." Is smoking a cigarette, which has been proven to be ultimately harmful, any worse than smoking marijuana, a drug whose beneficial medicinal qualities have been known for over a hundred years?

Good question! We have no ready answer and for this reason ARIZONA MEDICINE recommends that an understanding of both the mind altering drugs and their users be obtained through adequate committee study, and that the results of such a study be used for the adoption of a rational answer to the recognition and solution of the problems of both the M.A.D. drugs and their users. We, as physicians, have these responsibilities relative to a problem of this scope and magnitude; a responsibility to ourselves, our patients, our profession, and to our State.

Roland F. Schoen, M.D.
Editor



No one should be cold on a Caribbean cruise

To those with peripheral vascular disease, a balmy ocean breeze can become a limb-chilling wind . . . a stroll on the deck a painful, stop-and-go chore.

Priscoline can help. It dilates peripheral blood vessels, increases blood flow to extremities. Relieves numbness. Makes hands and feet less prone to chill. Makes patients more comfortable. Helps them get around.

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peripheral vasodilator

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Priscoline®
hydrochloride
(tolazoline hydrochloride)



Indications Spastic peripheral vascular disorders.

Precautions Tolazoline stimulates gastric activity and increases hydrochloric acid content of the stomach; use cautiously in patients with gastritis or peptic ulcer or in those with suspected peptic ulcer. Give cautiously, if at all, to patients with known or suspected coronary artery disease.

Adverse Reactions Occasional: nausea, epigastric discomfort, tachycardia, flushing, slight rise or fall in blood pressure, increased pilomotor activity with tingling or chilliness. Rare: vomiting, diarrhea. Symptoms are generally mild and frequently disappear with continued therapy, regardless of dosage.

Administration and Dosage Careful individualization of dosage is required.

Oral *Tablets:* Usually 25 mg 4 to 6 times daily is sufficient. If necessary, dosage may be increased gradually up to 50 mg 6 times daily.

Lantabs: Generally, 1 Lontab every 12 hours will achieve the same effect as one 25-mg regular tablet every 4 hours (6 times a day). Thus, continuous action throughout the night is achieved without the need for arising to take additional medication.

Parenteral *Subcutaneously, Intramuscularly, or Intravenously:* 10 to 50 mg 4 times daily. Start with low doses, increasing with patient under close observation until optimal dosage (as determined by appearance of flushing) is established. Keeping patient warm will often increase effectiveness of drug.

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Precautions: Electrolyte abnormalities may be aggravated or produced. Caution is important during prolonged or intensive therapy and when salt intake is restricted. Hypokalemia has been mild and infrequent, and other electrolyte abnormalities rare. The possibility of potassium depletion and its toxic sequelae must be kept in mind, particularly in cirrhotics and patients receiving digitalis. As a preventive measure the use of foods rich in potassium, such as orange juice, may be desirable. Although not a thiazide, HYDROMOX may possess certain characteristics of the thiazides. They have been known to cause jaundice with liver involvement and pancreatitis; hematological complications such as purpura with or without thrombocytopenia and leukopenia (neutropenia); increases of serum uric acid; decreased glucose tolerance as evidenced by hyperglycemia and glycosuria thus aggravating or provoking diabetes mellitus and azotemia in patients with renal disease; photoallergy. Discontinue use a few days prior to elective surgery. When added to a regimen that includes ganglionic-blocking agents, the dosage of these latter preparations should be reduced. Also reduce dosage when one or more of these antihypertensive agents is added to an established HYDROMOX regimen. Contraindicated in anuria. Observe for possible hematologic complications.
Side Effects: Skin rash; gastrointestinal disturbances (chiefly nausea), weakness, dizziness. These seldom require cessation of therapy, and can be relieved by reducing dosage or correcting electrolyte imbalance.
Warning: Enteric coated potassium tablets have been implicated in small bowel lesions and should be used only when adequate dietary supplementation is not practical.

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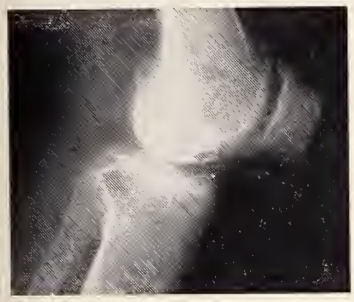
Tandearil® in Osteoarthritis
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

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But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil®
oxyphenbutazone

vate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis) or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response. Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

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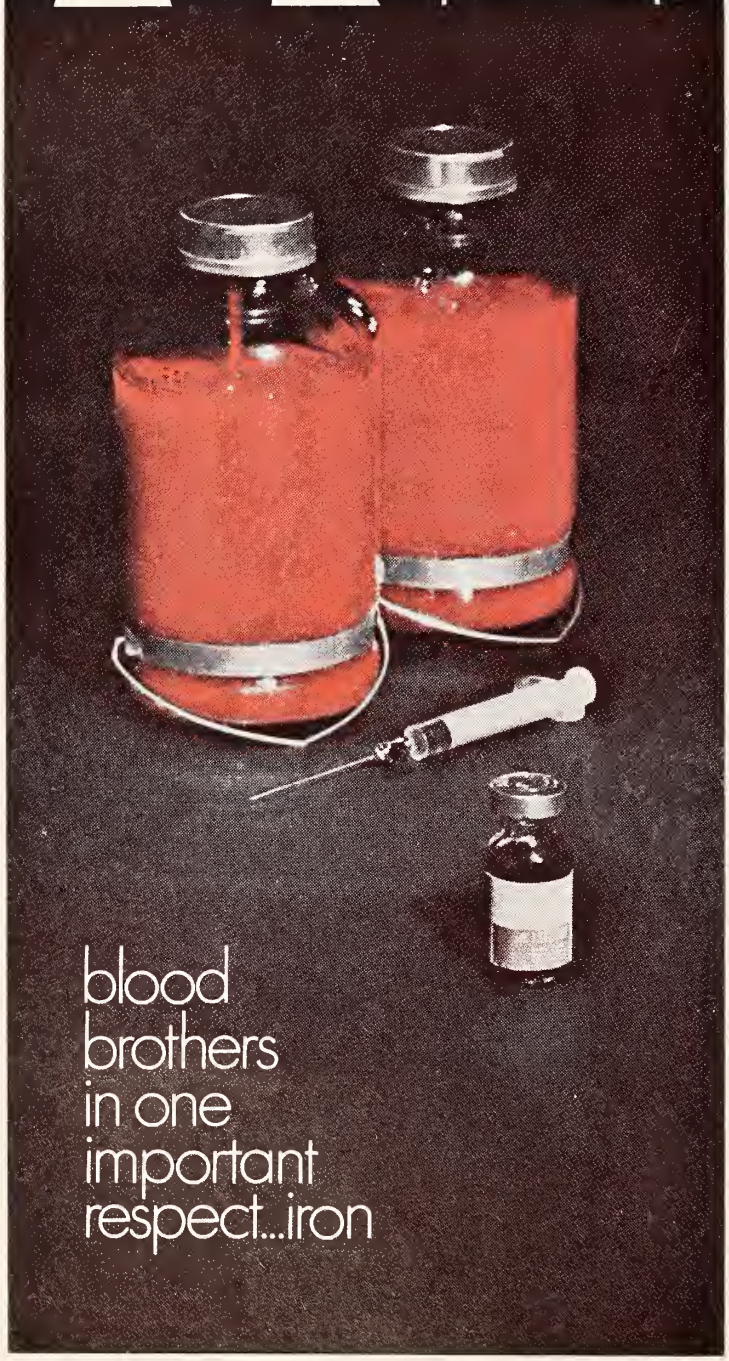
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IMFERON®

(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

See package insert for complete prescribing information.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

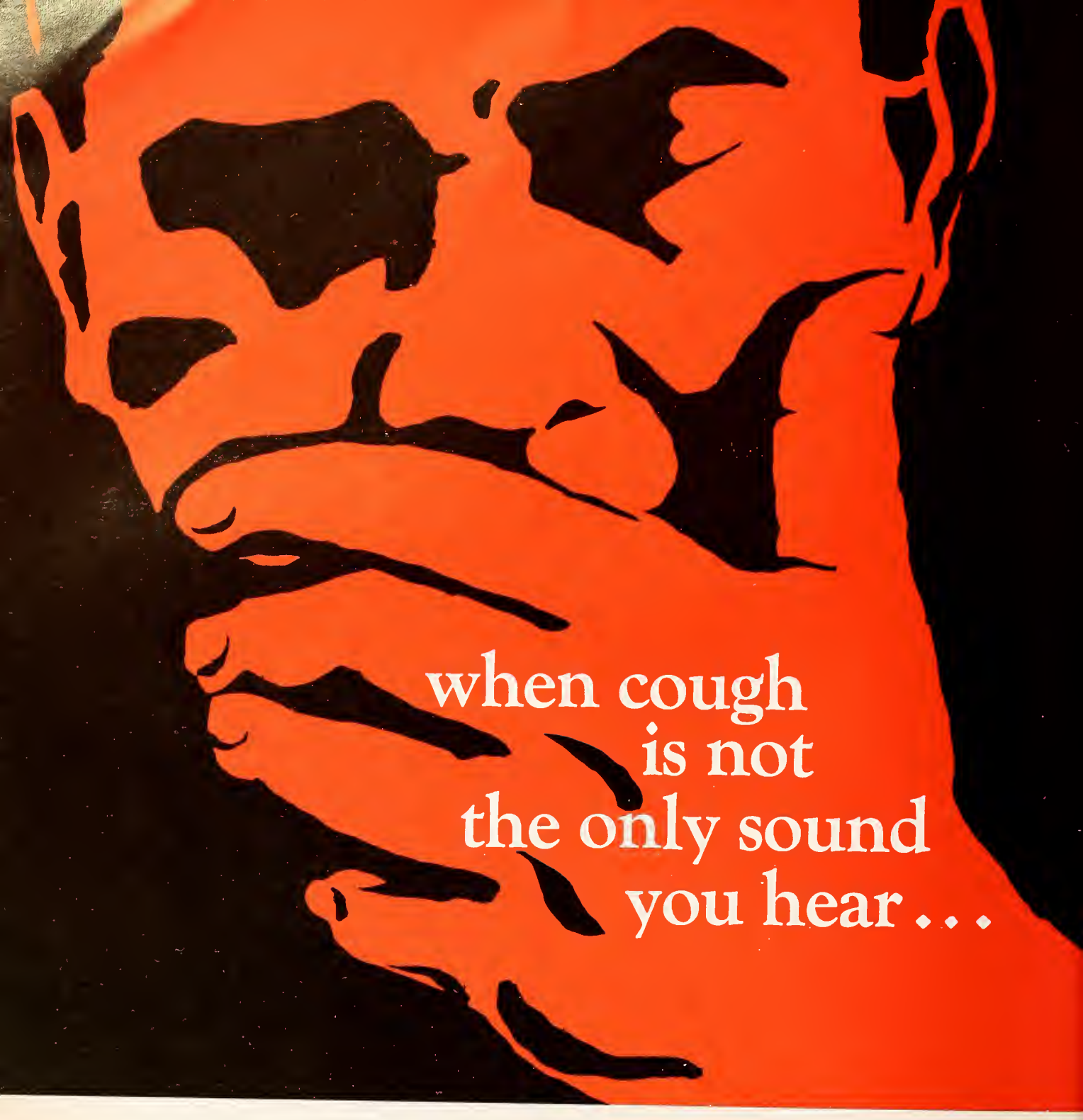
Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

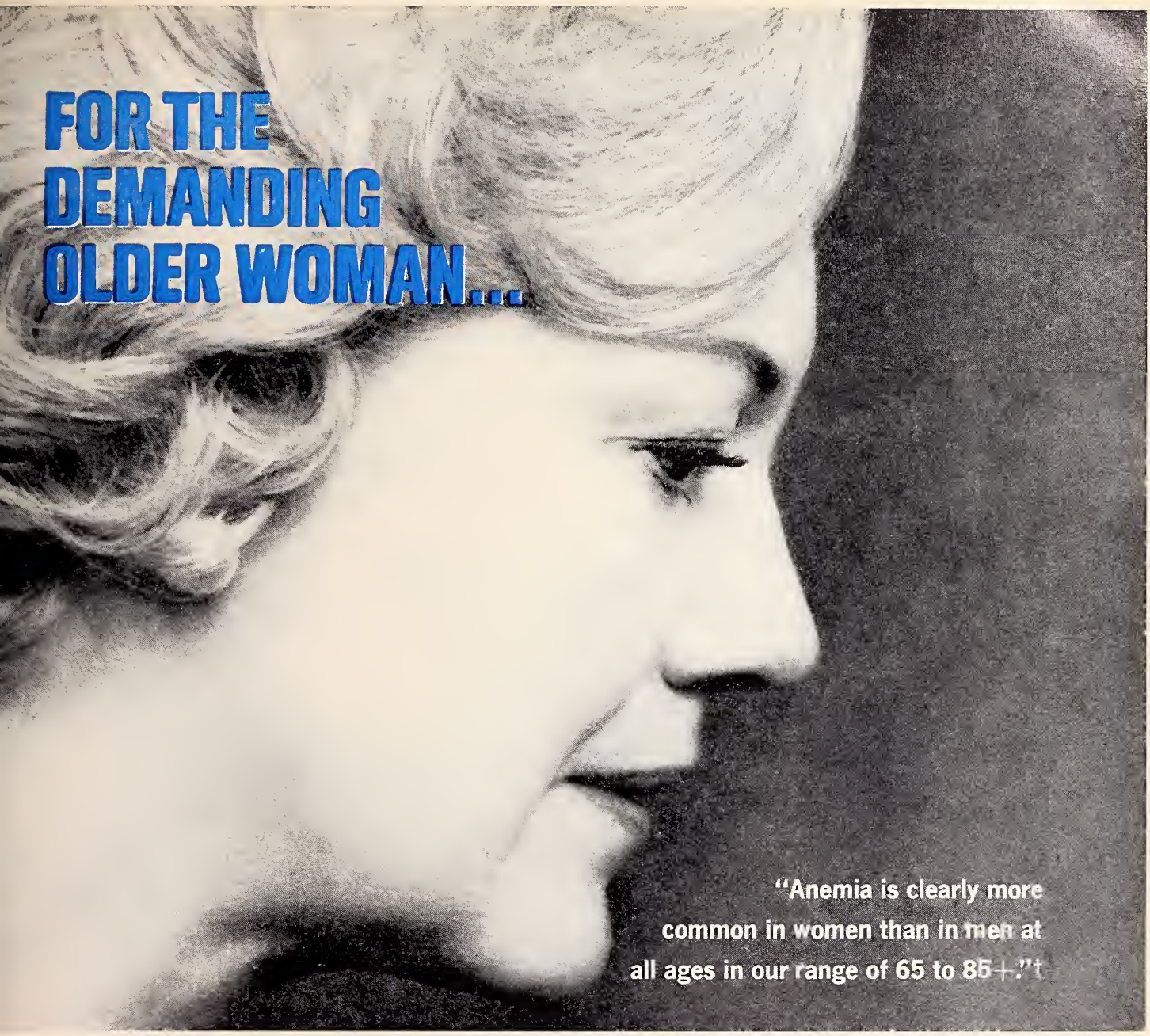
Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.



sustained-release

Mol-Iron® Panhemic Chronosule®*

capsules

To help overcome the inadequacies of poor absorption and insipid diet common in the geriatric patient—a superior, sustained-release hematinic combined with key vitamins.

Each Mol-Iron Panhemic Chronosule capsule contains: Ferrous sulfate, 390 mg. (78 mg. elemental iron) and Molybdenum sesquioxide, 6 mg. in sustained-release form; Vitamin B_{12}, 25 mcg.; Vitamin B_1, 6 mg.; Vitamin B_2, 6 mg.; Vitamin B_6, 5 mg.; Niacinamide, 30 mg.; Vitamin C, 150 mg. Supplied: bottles of 30.

*brand of sustained-release capsule

†Parsons, P.L., Withey, J.L., and Kilpatrick, G.S : Practitioner 195:656, (Nov) 1965.

White Laboratories, Inc.
Kenilworth, N.J.

BETTER TOLERATED—HELPS ASSURE MORE PREDICTABLE ABSORPTION AND OPTIMAL HEMOGLOBIN RESPONSE

SUPERIOR TO CONVENTIONAL FERROUS SULFATE

In 'Toler-ability'

Slowly-liberated,molybdenized ferrous sulfate virtually eliminates gastrointestinal side effects.

So well tolerated it can be taken on an empty stomach.

In 'Absorb-ability'

Gradual release of better tolerated, molybdenized ferrous sulfate helps assure more predictable absorption.

In 'Dose-ability'

Just a single Mol-Iron Panhemic Chronosule capsule daily generally corrects mild to moderate hematologic and nutritional deficiencies.

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ArMA Reports

PROFESSIONAL COMMITTEE

Meeting of the Professional Committee of the Arizona Medical Association, Inc., held Sunday, June 9, 1968, in the Convention Center of the Safari Hotel, 4611 North Scottsdale Road, Scottsdale, Arizona, convened at 10:45 A.M., William G. Payne, M.D., Chairman, presiding.

ROLL CALL

PRESENT: Drs. Antos, Robert J.; Cutts, Robert I.; Dexter, Richard L.; Fatheree, Jack D.; Ganelin, Robert S.; Heileman, John P., Secretary; Kohl, Jr., Harold W.; McDaniel, W. Shaw; Melick, Dermont W.; Payne, William G., Chairman; Schaller, Donald F.

Staff: Messrs. Carpenter, Robert, Executive Secretary; Robinson, Bruce E., Assistant Executive Secretary.

Guests: Drs. Hirsch, Louis (Tucson) — Arizona Society of Pathologists; Mann, Frank D. (Phoenix) — Arizona Society of Pathologists; Spendlove, George A., Commissioner, Arizona State Department of Health.

EXCUSED: Drs. Baker, Earl J.; Dudley, Jr., Arthur V., President; Flynn, Richard O., President-Elect; Helme, William B.; Rhu, Jr., Hermann S.; Wagner, Albert G.; Wood, MacDonald.

MINUTE

Approved minute of the Professional Committee meeting held February 18, 1968.

FINANCE

Reported, as of May 31, 1968, out of a total (1968) Budget of $5,000.00, there has been expended $1,395.38. The Chairman called attention to the need for conservatism to keep within the budget, as requested by the Board of Directors.

SECTION REPORTS

The Chairman made special note of the poor membership turnout this morning delaying the commencement of proceedings for three-quarters of an hour and then, just barely having a quorum to start. While a number of written reports were received by the Chairman from the Section Chairmen, it was suggested that in the future, Section Chairmen continue to prepare written reports to expedite the proceedings, but instead of mailing them, bring them to the meeting and present (read) them. Mailing of reports is and was not intended as a substitute for attendance. If it is not possible for a chairman of a Section to be present, he should designate one of his Section members to represent him. It appears that Sunday meetings are becoming less desirable and study must be given to a solution of the growing problem.

Aging and General Medicine

MEMBERSHIP

The Chairman, Dr. Kohl, Jr., suggested that any changes in his Section membership be deferred until need is demonstrated through activity of his assignments.

ARIZONA ADVISORY COUNCIL ON AGING AND THE AGED

Dr. Kohl, Jr. reported that he had received a letter from Governor Jack Williams thanking him on behalf of the aged citizens for his interest and service while a member of the Arizona Advisory Council on Aging and the Aged (an appointment which was not made). It was pointed out that the Legislature appropriated funds to the Department of Public Welfare to administer the State Agency on Aging and the Aged; therefore, the old State Agency administered by the Department of Health and its Advisory Council have been abolished and reconstituted under the Department of Public Welfare. A similar letter was forwarded to Dr. Paul B. Jarrett. RECEIVED.

POOLED PLASMA

The Committee on Blood of the American Medical Association called attention to a recent study and statement concerning the risk of hepatitis in using pooled plasma from large numbers of donors, prepared by irradiation and stored at 30-32° C. for six months. "The use of whole, pooled human plasma be discouraged and even discontinued unless a clearcut case can be made for its unique requirements" is a recent recommendation of the Committee on Plasma and Plasma Substitutes, Division of Medical Sciences, National Research Council. RECEIVED.

CLINICAL NUTRITION LECTURES

The AMA Council on Foods and Nutrition advised this Association will cooperate and co-sponsor (without financial involvement) planned lectures in clinical nutrition this Fall to be delivered by distinguished physicians. Its purpose is to inform students and faculty of recent developments in human nutrition and to stimulate interest in the biological sciences. Arizona State University, Northern Arizona University and the University of Arizona have been invited to participate. The geographical area selected includes: Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington and Wyoming. RECEIVED.

VISION AND HEARING SCREENING — PRE-SCHOOLERS

Dr. Kohl, Jr. reported receiving considerable correspondence from the Minnesota State Medical Association as regards its Pre-School Medical Survey of Vision and Hearing. Thousands of four-year-old youngsters are being screened for vision and hearing defects. As a result of recent publicity of its program in Parent's Magazine (February, 1968) and Reader's Digest (March, 1968), MSMA is being flooded with inquiries, many from Arizona. They were forwarded suggesting a similar program in this state. The Arizona Ophthalmological Society was communicated with inquiring whether it was familiar with such survey and whether it would be interested in developing such activity in Arizona.

Webster LeGene Sage, Jr., M.D., President-Elect, AOS, advised an active program is in effect throughout the state dealing with screening of pre-school children, in cooperation with the American Society for the Prevention of Blindness, with the aid of the Federated Women's Clubs.

Dr. Ganelin has agreed to investigate and report, as regards the hearing program in operation in Maricopa County.

It was regularly moved and unanimously carried that this Committee recommend to the Board of Directors

that it go on record endorsing the program of the Arizona Ophthalmological Society; and that screening of preschool children include both vision and hearing.

Allied Medical Groups

MEMBERSHIP

Daniel B. Carroll, M.D. (Phoenix) accepts appointment as member of the Section on Allied Medical Groups. Robert W. Weber, M.D. (Tucson) declines appointment account recent accident incapacitating him.

ACUTE CARDIAC CARE

In the absence of the Chairman, Dr. Payne reported pointing out that the Board of Directors in meeting held in 1967, endorsed the "Joint Statement on Acute Cardiac Care" prepared and submitted by the Arizona State Nurses' Association. In Board meeting held November 12, 1967, emphasis having been placed on the "properly trained and competent to perform" nurse under direction of the physician, concurred in the recommendation of the Professional Committee of the importance of establishing legal responsibility in these cases, such responsibility to be carefully spelled out; and that all physicians in the state working in hospitals in this area be similarly informed in order that they may know exactly where they stand. Responses have been received from Northwest Hospital, Glendale; Mesa Lutheran and Southside District Hospitals, Mesa; Doctor's, St. Joseph's and St. Luke's Hospitals, Phoenix; Baptist Hospital of Scottsdale; Tempe Community Hospital; St. Mary's Hospital of Tucson, Tucson; and Tucson Medical Center; and Parkview Baptist Hospital, Yuma. Good Samaritan and John C. Lincoln Hospitals, Phoenix, failed to respond. Discussion ensued. Question was raised as to whether there should now be prepared a suggested model set of rules and regulations or guidelines for acute cardiac care for Board approval following advice of Counsel.

Determined to request Dr. Helme to give consideration thereto; review all responses received, compare one with the other pointing out areas of disagreement or agreement in summary form, review with Counsel and report.

PODIATRY

The Board of Directors in meeting held March 10, 1968, determined not to introduce a resolution proposed by the Professional Committee to the effect that hospitals within the State of Arizona be enocuraged to conform to guidelines as expressed in Bulletin No. 44 of the Joint Commission on Accreditation of Hospitals, April, 1967 issue, when considering the granting of staff privileges to Podiatrists. This determination did not preclude introduction of such a resolution by a Delegate or a component county medical society. RECEIVED.

TREATMENT OF PHYSICIANS' FAMILIES

The Board of Directors in meeting held March 10, 1968, determined that the "ethics" of paying doctors of medicine for treating members of his own family (such as in the instance of Blue Shield coverage) is highly questionable and certainly frowned upon by the Arizona Medical Association. RECEIVED.

NURSES' RECOGNITION DAY

AMA urges promotion of "Nurses' Recognition Day" programs within communities in recognition of their significant health care contributions continuously being made and their dedication to the task. Dr. Payne stated he would include this item for discussion on the agenda of the next liaison meeting between ArMA-ASNA scheduled to be held in Flagstaff July 20, 1968.

PLANNED TECHNICAL EDUCATION

Dr. James L. Gibson, representing the Maricopa County Junior College District, visited the Central Office to familiarize ArMA with a program in progress currently, principally in hospitals, providing technical education in the areas of nursing (pre-practical), surgical techniques, and ultimately to enter the field of radiological technicians, etc. He sought the privilege of presenting the program officially to this Committee. GRANTED NEXT MEETING.

INTRAVENOUS ADMINISTRATION OF FLUIDS

Dr. Payne presented a proposed: "Joint Statement by the Arizona Medical Association, the Arizona Hospital Association, and the Arizona State Nurses' Association, on the Intravenous Administration of Fluids (including blood) by Professional Registered Nurses Practicing in the State of Arizona," recommending approval.

It was regularly moved and unanimously carried that the Professional Committee recommend to the Board of Directors approval of this joint statement.

ArMA-ASNA Liaison

MEMBERSHIP

Dr. Payne reported membership composite as follows: ArMA — Drs. William G. Payne, Chairman (Tempe); Boyden L. Crouch (Phoenix); Arthur V. Dudley, Jr. (Tucson); Arnold H. Dysterheft (McNary); Richard O. Flynn (Tempe); and Joseph C. White (Phoenix). Dermont W. Melick, M.D. (Tucson) withdraws.

ASNA — Rosamond Gabrielson, R.N., President — ASNA (Phoenix); Hazel Bennett, R.N. (Phoenix); Dorothy Corona, R.N. (Tempe); Beatrice Evans, R.N. (Flagstaff); Sister John Richard, St. Joseph's Hospital (Tucson); and Betty Spaulding, R.N. (Tucson).

The next meeting is scheduled to be held in Flagstaff, Arizona, July 20, 1968.

Athletic Medicine

MEMBERSHIP

Appointed C. Herbert Fredell, M.D. (Flagstaff); Robert L. Hagan, M.D. (Tucson); Henry P. Limbacher, M.D. (Tucson); Louis Hirsch, M.D. (Tucson); Warren D. Eddy, M.D. (Tucson); Gabriel L. Cata, M.D. (Tucson); Richard F. Dahlen, M.D. (Tucson); and lay members: Dr. William Stone (Tempe); Messrs. John Barringer (Tucson) and W. K. Carson (Tucson); all members of the Section on Athletic Medicine; Richard L. Dexter, M.D. (Tucson) serving as Chairman. It was suggested a note in Medical Memos of these appointees would be helpful with comment that each would be receptive to service, if called upon.

ACTIVITIES

Dr. Dexter and one member attended a conference on sports medicine held in Houston, sponsored by the AMA, found to be a very valuable experience. An annual conference on the subject is held in Rhode Island in August each year primarily dealing with orthopedic surgery. This year other aspects will be considered and special attention will be given to female athletics. Activities involving the chairman's appointments to AAU, USJF National Advisory Committee have taken place; careful review of the Arizona Interscholastic Association's regulations particularly with regard to medical care coverage

from both training and sports events aspects, undertaken by members of the Section; and it should be pointed out by the Section to AIA that when the word "physician" is used, it refers only in Arizona to a Doctor of Medicine or a Doctor of Osteopathy, not any of the other healing arts. RECEIVED.

Disaster Medicine

MEMBERSHIP

In the absence of Dr. Baker, no report presented involving membership.

1968 IMMUNIZATION PROGRAM

The Board of Directors, in meeting held March 10, 1968, determined not to authorize an appropriation of $2,000.00 for a continuation of the statewide immunization program in 1968, suggesting that such activity be carried out on the local level by the component county medical societies, if desirable. RECEIVED.

PUBLIC HEALTH AND MEDICAL DEFENSE COURSE

Approved the expenditure of $312.40 by Earl J. Baker, M.D., Chairman, in attendance at a Public Health and Medical C. and B. Defense Course held at Fort McClellan, Alabama, March 18-22, 1968.

1967-68 ANNUAL REPORT

In the absence of Dr. Baker, Dr. Schaller presented the Chairman's annual report, dated April 25, 1968. The major accomplishments include: (a) completion of a symposium on Health Mobilization and Disaster Preparedness in conjunction with the Arizona State Health Department, the State Department of Civil Defense and Emergency Planning, and the Continuing Education Division of the University of Arizona; (b) completion of a statewide adult immunization program for diptheria, tetanus and smallpox with a concomitant measles pediatric phase, between September 1 and November 17, 1967, immunizing approximately 77,000 citizens in Arizona; (c) attended the Public Health and Medical C. and B. (Army School) defense course previously reported; (d) review of the present communication network in the event of disaster; and recommended support by ArMA of a low gear reamplification of the Immunization Program in the fall of 1968 (Board of Directors determined such activity, if desirable, should be carried out on the local level). RECEIVED.

COMMUNICATION SYSTEMS RESOLUTION

Approved the following resolution submitted jointly by Donald F. Schaller, M.D. and Earl J. Baker, M.D., Chairman, members of the Section on Disaster Medicine, recommending that it be referred to the Board of Directors for consideration and like approval.

WHEREAS, a lack of communication or breakdown in communication has been the greatest single problem in every disaster, large or small, in this country, and

WHEREAS, planning for casualties, multiple or single, occurs most often when patients arrive at hospital emergency rooms, and

WHEREAS, in Arizona there is practically no real day to day coordination between sites of accidents, emergency vehicles, policy agencies and hospitals, and

WHEREAS, in the State of Arizona there are many fine and well thought-out communication systems, although there is much duplication of facilities, services and dispatching headquarters, and

WHEREAS, most of these systems are presently organized in a vertical fashion; i.e., for the strict use of a specific department with no real coordinated effort being made to provide horizontal communications; i.e., interdepartmental or agency communications of facilities to permit the use of one piece of equipment for several departments or services, therefore be it

RESOLVED, that:

1. A coordinated effort be made to survey all communication systems operating throughout the state. This effort should survey budget requirements, equipment in existence and its capabilities, as well as equipment needs for the future.
2. After completion of such survey, steps be taken to establish for the entire State of Arizona:
 - A. A formal coordination of all communication systems.
 - B. A central communications authority to establish policies as well as emergency control over the various systems, their equipment, frequencies and channels.
 - C. A unified budget for communications in the State.
 - D. Central dispatching for all systems.
 - E. Establishment of alternative communication system for the use in event of failure of the primary system.
 - F. Daily use and coordination of all services and agencies, whether state, county, municipal or other (medical, hospital and ambulance facilities).
 - G. Daily coordination in contact with civil defense agencies.
 - H. Daily inter-agency contact between all agencies and departments which would be essential in the event of a disaster, large or small; i.e., police agencies on one line, fire departments on another line, ambulance services on another line, hospitals, physicians and others.
 - I. Maintain essential continuing contact specified physicians to provide immediate consultation in emergencies through the use of a two-way radio system.

Emergency Care

MEMBERSHIP

Appointed William W. McKinley, Jr., M.D. (Bisbee) a member of the Section on Emergency Care.

REGIONAL MEETING

The Board of Directors in meeting held March 10, 1968, approved in principle the holding of a Regional Emergency Medical Services meeting to encompass possibly eleven western states, but without financial support. Cooperation of the AMA in this objective has been solicited. RECEIVED.

AMBULANCE EQUIPMENT AND PERSONNEL

Dr. Schaller reported in detail the results of the hearing held by the Arizona Corporation Commission in Phoenix, May 17, 1968, in consideration of its Order

prescribing rules and regulations for ambulance equipment and its personnel. Its decision is being awaited.

AMES PROGRAM

The Chairman reviewed at considerable length the AMES (Air Medical Evacuation System) demonstration program. Presented was a report on program evaluation, program management concept and budget prepared by the Division of Industrial Design and Technology of Arizona State University. It is designed for helicopter and ground ambulance crews in rescue and evacuation of highway accident injured and injured otherwise. The objective will be achieved through the cooperation of many organizations including Arizona State University, Arizona Highway Patrol, Arizona Medical Association, Arizona Hospital Association, Forestry Service, Park Department, Civil Defense, Indian Reservation Agencies, etc., to mention but a few. APPROVED.

Appointment of a steering committee is desirable and it is recommended that the Board of Directors give consideration thereto.

COMMUNITY-WIDE ACTION PROGRAMS

Charles L. Hudson, M.D., Director, AMA Division of Health Service, urges this Association to give renewed effort to fostering an awareness of the need for and the development of community-wide action programs on emergency services. RECEIVED.

EMERGENCY MEDICAL SERVICES

Irvin E. Henderson, M.D., Chairman of the AMA Commission on Emergency Medical Services, seeks information as regards this Association's emergency medical services activities. The inquiry was forwarded to Dr. Schaller, Chairman, for response, who filed a copy thereof with this Committee for its information. It outlined the many projects already being participated in within this area of responsibility. RECEIVED.

MEETING RECONVENED AT 2:25 P.M., ALL MEMBERS PRESENT DURING THE MORNING SESSION RESPONDING "AYE" TO THE ROLL CALL, EXCEPTING ROBERT J. ANTOS, M.D., RICHARD L. DEXTER, M.D., AND JACK D. FATHEREE, M.D., WILLIAM G. PAYNE, M.D., CHAIRMAN.

Industrial Health

Dr. Fatheree, Chairman, was excused. As a new member, he had nothing to report at this time.

Medical Education

MEMBERSHIP

Dr. Melick, Chairman, expressed a desire to be relieved of this assignment. He feels that the activity needs a new Chairman and new orientation to the whole approach. He is willing to serve as a member of the Section, but not as Chairman, if it is felt he could be helpful. This decision might affect his membership on the Professional Committee; his term of appointment was and is 1966-69. Oscar A. Thorup, Jr., M.D., University of Arizona College of Medicine, suggested as a replacement, if he will accept the assignment. Other membership appointments held in abeyance.

TELEVISION PROGRAM

Approved expenses of Boyden L. Crouch, M.D., Chairman, Subcommittee on Television, for the period January 5, 1968 to June 1, 1968, totaling $370.78, which included attendance March 14-16, 1968, AMTVB (American Television Broadcasters) Convention, Hollywood, California ($105.513, and meeting of the Council on Medical Television, May 1, 1968, at Houston, Texas ($195.22).

It was pointed out by Dr. Melick that the television activity was considered to be of enough importance to request a $5,000.00 budget. This is not possible nor practical in view of the total budget allotted, he stated.

Medicine and Religion

MEMBERSHIP

Karl E. Voldeng, M.D. (Phoenix) and the Reverend Richard C. Zollner (Scottsdale) accept appointment to membership on the Section on Medicine and Religion.

In the absence of Dr. Wagner, no reported submitted.

Mental Health

MEMBERSHIP

No report.

MILITARY REJECTEE CRITERIA AMA-APA

Walter Wolman, Ph.D., Director of the AMA Department of Mental Health, reports in the matter of rejection on registrants for military service for psychiatric reasons which has been the concern of this Section. To say the least, the problems are frustrating. RECEIVED.

MEDICAL HYPNOSIS

In the matter of feasibility of establishing policy relating to participation of member physicians in lay-sponsored (Phoenix College — Evening Division) medical educational programs ("hypnosis" in this particular instance), the Arizona Psychiatric Society comments. RECEIVED.

MULTI-DISCIPLINE UNIT — COCHISE COUNTY

Dr. Cutts reported he had received a copy of Dr. J. H. Stickler's letter of November 3, 1967, relating to establishment of a multi-discipline unit consisting of a General Practitioner of Cochise County Medical Society, a clergyman, lawyer, psychologist and social worker to counsel and interview disturbed patients who have been diagnosed and referred by a psychiatrist for follow-up control. No facility is available in Cochise to provide such treatment. Dr. Hubest Estes (Tucson), psychiatrist and staff, visits Bisbee once a month, to review disturbed children of the Family Guidance Clinic and sees a few adults discharged from the State Hospital. There appears no immediate answer to this problem; however, effort will continue to find a solution. RECEIVED.

Perinatal and Maternal Mortality

In the absence of the Chairman, no report available.

Poison Control

MEMBERSHIP

Dr. Antos remarked he is endeavoring to locate individuals from various parts of the state to fill out the membership of his Section on Poison Control. He will welcome suggestions. Advised to correspond with societies.

ACTIVITIES

A poison control center was established in 1966-67 at Mesa Lutheran Hospital. One is being developed currently at St. Luke's. The Chairman reviewed developments in respirators, an improvement over mouth-to-mouth resuscitation; development of a toxicology laboratory at ASU; and reported reaction (convulsive) to hexachlorophene when absorbed through the skin.

Public Health

MEMBERSHIP

Recommended appointment of Howard N. Kandell, M.D. (Phoenix) to serve as ArMA representative to the

Arizona Hospital Association-Educational Coordinating Committee. APPROVED.

Continues search to fill the vacancy in his Section of Chairman — Subcommittee on Rural and Migrant Health.

HEALTH RECORD FORM

In the matter of development of a standard health record form for use in schools of higher learning, Chairman requested to review those forms submitted by the various institutions; advise those schools that have sufficient medical data contained therein, possibly pointing out any deficiencies; this procedure in preference to calling a meeting of all concerned which might react unfavorably should it be felt ArMA is dictating what their form(s) should be.

VISION AND HEARING SCREENING PRE-SCHOOLERS

Previously reported upon under Section of Aging and General Medicine.

CLINICAL LABORATORIES LICENSING — REGULATING

Dr. Spendlove and Dr. Hirsch spoke to the previous legislative effort which failed to enact H.B. 53 (Second Regular Session — 28th Arizona Legislature) providing for licensing and regulating Clinical Laboratories and Blood Banks. This measure was introduced by Rep. Frank Kelley of District 8-D Maricopa. It did not have the approval of the pathologists of this state. Dr. Spendlove agreed to again try to bring the groups involved together, including general practitioners and internists. It was agreed the Section on Public Health under Dr. Ganelin would assist.

AMA CONFERENCE HEALTH EDUCATION

Dr. Ganelin reported upon the Third National Conference on Health Education of the Public, which he attended, held in Chicago, April 4-6, 1968, sponsored by the AMA. Keynote of the Conference was bridging the gap between the present day knowledge about health and prevention of illness and the accomplishment of illness prevention. Approved the expenditure of $372.00 therefor.

DEGREE-HEALTH ADMINISTRATION

The University of Colorado Medical Center plans to offer a Master of Science degree program in Health Administration beginning this fall. It is the hope that Hospital Associations, Public Health Departments and Medical Societies in the Mountain States will find the program of interest. RECEIVED.

ETHICAL COMPENSATION LEAVE OF ABSENCE

Determined "ethics" not involved; that it is usual and customary for a doctor on prior satisfactory agreement to compensate another doctor who cares for his patients when he is absent from town. Directed that Coconino County Medical Society be so informed.

USPHS — INDIAN SERVICE

Determined to refer to the Board of Medical Examiners of Arizona the matter of treating civilian employees of the USPHS Indian Service by medical staff in isolated institutions at Kings Canyon, Sells, White River and Parker.

PHYSICAL EDUCATION FOR CHILDREN

Boyd H. Metcalf, M.D. (Scottsdale) inquired as regards the present policy and extent of activity in physical education for children within the state. Is it adequate? Is there some consideration for change? What plans are there for the future? Is it possible to expand this program to include parents (adults)? Referred to the school health subcommittee for investigation and report.

MATERNAL & CHILD HEALTH CARE

Dr. Ganelin reports he has corresponded with the Woman's Medical College of Pennsylvania in the matter of its proposed program to retrain physicians in maternal and child health care who for illness, child bearing or other factors have not maintained active involvement in the medical profession. RECEIVED.

AIR POLLUTION CONTROL DATA

Dr. Spendlove appealed to anyone having clinical evidence on air pollution being harmful to report, thereby assisting his department in studies currently being undertaken. RECEIVED.

NURSE-MIDWIFERY

Referred to the Section on Perinatal and Maternal Mortality, the joint report of the Arizona State Nurses' Association and the Phoenix Obstretrical and Gynecological Society in the matter of nurse midwifery, with instructions that the report be reviewed and the subject pursued further to determine feasibility of arriving at a joint statement.

COMMUNITY HEALTH WEEK

Determined to communicate with the component county medical societies at the appropriate time when officially informed of Community Health Week to be considered on the local level.

Safety

MEMBERSHIP

Appointed Drs. Peter M. Cole (Scottsdale); Howard H. Johnston (Phoenix); Henry P. Limbacher (Tucson); Richard T. McDonald (Flagstaff); and Albert G. Wagner (Phoenix), members of the Section on Safety.

In the absence of the Chairman, no report submitted.

Woman's Auxiliary

Dr. McDaniel advised he had received no inquiries from the Woman's Auxiliary; therefore, he had no report at this time.

MEETING ADJOURNED AT 3:49 P.M.

John P. Heileman, M.D.
Secretary

MEDICAL ECONOMICS COMMITTEE

Meeting of the Medical Economics Committee of The Arizona Medical Association, Inc., held Sunday, June 30, 1968, in the Central Office of the Association, Suite 201, Safari Building, 4601 North Scottsdale Road, Scottsdale, Arizona, convened at 10:15 A.M., Ian M. Chesser, M.D., Chairman, presiding.

ROLL CALL

PRESENT: Drs. Armstrong, Richard S.; Chesser, Ian M., Chairman; Crawford, Robert F.; Dregseth, Kenneth A.; Dudley, Jr., Arthur V., President; Heileman, John P., Secretary; Hoffmann, George L; McGregor, Jr., John G.; Ricker, John H.

Staff: Mr. Carpenter, Robert, Executive Secretary.

Guests: Drs. Hardenbrook, Richard G. (Prescott); Tyler, G. Scott (Phoenix).

EXCUSED: Drs. Brown, Harvey G.; Flynn, Richard O., President-Elect; McDonald, Richard T.; Melick, Dermont W.; Smith, Gregory C.

MINUTES

Minutes of the meeting of the Medical Economics Committee held February 11, 1968, reviewed and approved.

FINANCES

It was reported that out of a 1968 Budget of Appropriation of $700.00, this Committee had expended to May 31, 1968 (inclusive) $459.56. RECEIVED.

CHAPTER 6, LAWS OF 1968- WORKMAN'S COMPENSATION

H.B. 1 of the 4th Special Session of 28th Legislature of the State of Arizona is now Chapter 6, Laws of 1968. It provides for the revision of the State Workman's Compensation Administration Code and creation of an Industrial Safety Code, effective January 1, 1969.

Section 13. Sec. 23-908, Arizona Revised Statutes, is amended to read in part:

23-908 **Injury Reports by Employer and Physician; Fees of Physician; Violations; Penalty**

A. Every employer affected by the provisions of this chapter, and every physician who attends an injured employee of such employer, shall file with the commission and the employer's insurance carrier from time to time a full and complete report of every known injury to the employee arising out of or in the course of his employment and resulting in loss of life or injury. Such report shall be furnished to the commission and such insurance carrier at times and in the form and detail the commission prescribes, and shall make special answers to all questions required by the commission under its rules and regulations.

B. The commission shall fix a schedule of fees to be charged by physicians attending injured employees, which shall be reviewed annually by the commission.

(C. - D. - E. - F. - G. - H. follow)

Dr. Chesser reviewed in detail the efforts of this Association before and through the Second Regular and following Fourth Special Sessions of the 28th Arizona State Legislature relating to the re-organization of the Industrial Commission of Arizona in an effort, among other things, to have eliminated the required fee schedule provided for the payment of physicians' fees associate with industrial injury cases, substituting therefor the application of the usual, customary and reasonable fee concept now being recognized in other governmental operations. While the effort was unsuccessful, it can be said that possibly two points were achieved: (1) the schedule of fees to be charged by physicians attending injured employees, now required, "**shall**" be reviewed annually by the commission"; and (2) there has been deleted from the previous statutory requirement that such fees "**shall not be exceeded**". The desired UCR amendment proposed by ArMA did clear the House and two committees of the Senate though amended somewhat in that chamber; however, when the bill reached the Joint Conference Committee of both Houses, the result was as reported here.

The question: where do we go from here? Do we continue to negotiate with the Industrial Commission prior to January 1, 1969, the effective date of the new law, or what position should ArMA take? Who will constitute the membership of the ICA January first next? Lengthy discussion ensued.

Letters were presented and read, received from Walter V. Edwards, M.D., Medical Director, Industrial Commission of Arizona and Chester G. Bennett, M.D. (Phoenix).

The chairman pointed out that during the negotiations over the past number of months, the thing that had not been done was to contact our people who are rendering services in industrial cases to obtain their opinion as to the adequacy of the fee schedule. It is his feeling that a short but meaningful survey of the doctors in the state should be undertaken to ascertain what they think about this, and if the attitude seems to be that they want more than the 5.5 factor, if they want changes made, then, we will go ahead and attempt to do something. Under the present situation, it was his opinion that the Assoeiation should have an on-going program of negotiations with the Commission now, and in those areas where there are obvious inequities, endeavor to have them adjusted.

It was regularly moved and unanimously carried that it be the recommendation of the Medical Economics Committee to the Board of Directors of the Association: (1) that the Association adhere to the directive contained in Resolution No. 3 adopted by the House of Delegates, as amended, April 27, 1968, the Association again going on record "favoring the concept of usual, customary and reasonable fees in its negotiations with the Legislature and the Industrial Commission of the State of Arizona"; (2) that since the statute (Chapter 6, Publie Laws of 1968 — Fourth Special Session of the 28th Arizona Legislature, effeetive January 1, 1969) provides: "the commission shall fix a schedule of fees to be charged by physicians attending injured employees, which shall be reviewed annually by the commission (Sec. 13. Sec. 23-908B.)", this Association, through its Medical Economics Committee, proceed to negotiate with whomever it should be to adjust the fee schedule either upwards or downwards, in line with the usual, customary and reasonable fee concept; and (3) in an endeavor to determine among member physicians the percent of individual praetice devoted to industrial cases, that a mail survey be authorized conducted by the Medical Economics Committee, among the various member professional groups within the state, seeking such information and data regarding charges.

Dr. G. Scott Tyler, M.D. (Phoenix) expressed appreciation and thanks to be privileged to sit-in on the discussion this morning and obtain first hand the views and opinions of this committee in the matter of industrial injury cases in the light of the recently enacted Industrial Commission reorganization legislation. He left the meeting at this point.

INDUSTRIAL PATIENTS — FREEDOM OF CHOICE

Dr. McGregor reported concern of one of the Tucson orthopedie physicians as regards the lack of freedom that an industrial patient has in seeking out his own physician. The twenty-six member Tucson Clinic has established contractual arrangements with several of the mining companies, principally industrial agencies, whereby that Clinic becomes the physician for the company;

thus, if the patient (employee) is injured on the job, the patient, regardless of who his private physician is, must go to that Clinic to obtain his care; otherwise, he loses his industrial benefits. This abrogates freedom of choice. It is felt this committee should become concerned over such practice as to whether it is ethical.

It was regularly moved and unanimously carried that it be the feeling of this Committee that such contractual arrangements are unethical and not in the best interest of the practice of medicine and freedom of choice concept; therefore, it is proposed to the Board of Directors that the Arizona Medical Association declare such contractual arrangements unethical, and that member physicians be urged to cease and desist therefrom.

VOLUNTARY HEALTH AGENCIES

Dr. Melick reports he is not interested in continuing as chairman of the Section on Voluntary Health Agencies. The committee has had one short formal and one informal meeting. Basically informational and for orientation purposes. The groundwork has been accomplished for the institution of an active program. A wealth of material is available for the new chairman and his committee members. Question was raised as to whether this function should be part of the Professional Committee activity. Possibly a new chairman should be appointed. He could then decide. NO ACTION TAKEN.

BLUE CROSS - BLUE SHIELD SURVEY

Dr. Melick reported that the Blue Cross-Blue Shield full-time salaried hospital physician employee survey proved unable to come up with specifics or recommendations, this despite four separate and distinct and well attended meetings. The problem is immense, complicated and of such importance that a continuation of the committee is contemplated with the eventual make-up of a set of guidelines. RECEIVED.

MEETING ADJOURNED AT 12:45 P.M.

John P. Heileman, M.D.
Secretary

Special Building Program Meeting

September 5, 1968 — 8:00 P.M.
(Cocktails at 7:30 P.M. — this is not a dinner meeting)

The Smokehouse Restaurant
4701 N. 16th Street — Phoenix

If you have questions that need answering, plan to attend.

24-HOUR AIR AMBULANCE SERVICE



A. L. MOORE & SONS
Mortuary and Air Ambulance Service
Adams at Fourth Ave. / Phoenix / AL 2-3411



What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa.

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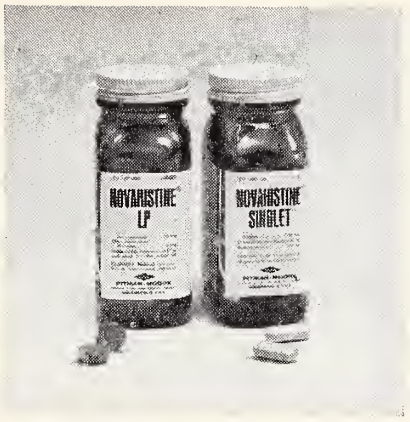
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ERYTHROMYCIN-SULFAS IN PEDIATRIC PRACTICE:

Efficacy and Patient Acceptance

W. Scott Chisholm, M.D.

An interesting article from a practical standpoint if one keeps in mind two points: (1) that coagulase-negative staph and alpha strep are probably not pathogenic organisms, and (2) when one uses a combination of drugs in a single preparation, he cannot always have optimum dosage (mgm/Kgm/24 hrs.) of both at the same time.

The clinical appearance of the throat in children with upper respiratory infections can be deceptive. The inability of the clinician to single out with certainty those infections due to Group A beta-hemolytic streptococci is established.[1, 2] Bacteriological data is mandatory for specific treatment. On the other hand, knowledge of the season, the weather, and current local community infections often suggests a particular choice of therapy.

There is little question about the use of penicillin or erythromycin alone when streptococcal infection seems likely. However, under many conditions, wider bacterial coverage may be useful and indeed necessary. Tetracyclines, until recently, offered some assurance of this broader coverage. But the revelation that incorporation of tetracyclines into developing teeth can give rise to permanent staining[3] clearly argues against using these agents in children unless no alternative exists. Also, the emergence of tetracycline-resistant strains of streptococci[4, 5] and pneumococci[5, 6] together with the somewhat marginal activity of these agents on staphylococci[5, 7] add urgency to the need for re-examining other methods of obtaining broad antimicrobial coverage.

The choice is, in fact, somewhat limited. Ampicillin, while theoretically promising, still shares penicillin's problems of allergy and destruction by penicillinase[8]. The cost of this drug may also need to be considered. In the case of lincomycin, an uncomfortably high incidence of gastrointestinal problems limits its usefulness[9]. The sulfonamides have only moderate activity against beta-hemolytic streptococci[10]; furthermore, their effect, being basically bacteriostatic, may not be as rapid as would be desirable. However, the sulfas do offer activity against the gram-negative organisms that occasionally cause upper respiratory infections.

It would seem that no single agent yet offers the broad coverage that may be needed in managing upper respiratory infections. Recently, however, an erythromycin-triple sulfonamide combination* has been developed in new dosage forms designed specifically for children. It was felt that this combination of agents merited re-examination as a means of obtaining wider bacterial coverage; hence, this study was undertaken to evaluate both the therapeutic efficacy of the new modality and the acceptability of its two dosage forms under the clinical conditions of private pediatric practice.

Methods and Materials

1. Choice of patients: The study group included 91 children, ranging in age from eight months to twelve years. Sites of infection were the respiratory tract or the skin. The range of clinical diagnoses is shown in Table IV. As can be seen, pharyngitis or tonsillitis accounted for almost two-thirds of the patients.

*Supplied under the trade name, Erythrocin-R-Sulfas, by George H. Berryman, M.D., Abbott Laboratories, North Chicago, Illinois.

2. *Drug forms and dosage:* The erythromycin-sulfas combination was supplied either as chewable tablets or as granules for reconstitution as an oral suspension. Each tablet, or 5-ml. teaspoonful of the suspension, provides 125 mg. of erythromycin (as erythromycin ethyl succinate), and a total of 501 mg. of sulfonamide, divided into 167 mg. each of sulfadiazine, sulfamerazine, and sulfamethazine. Both dosage forms are organge-flavored.

Dosage was calculated on the basis of body weight. Children under 50 pounds of body weight received one tablet or one 5-ml. teaspoonful of the suspension every four to six hours; children over 50 pounds received two tablets or spoonfuls of the suspension.

The age distribution for each dosage form is shown in Table I. Selection of dosage form was related to the ability of the child to handle a chewable tablet; in general, younger children were given the suspension.

Duration of therapy was five to seven days unless the infecting organism proved to be beta-hemolytic streptococci, Group A. In such cases, treatment was extended to ten to twelve days. In all patients, therapy was continued for 48 hours or more after symptoms had subsided and the temperature had returned to normal.

3. *Laboratory studies:* Cultures were taken for 63 patients; the organisms isolated are detailed in Table II. The most frequently found organism was indeed beta-hemolytic streptococci and, of the 26 cultures, 12 fell into the Group A classification. Five of the 63 cultures failed to show any growth at all.

White cell and differential cell counts were performed for 69 patients; as noted in Table II, the majority showed white cell elevation.

Results

Clinical response was classified by the following criteria:

Cured: Complete symptomatic relief within 72 hours.

Improved: Partial relief of symptoms within 72 hours; subsequent clinical cure.

Not improved: No effect within 72 hours.

In this series, 78 of the 91 patients, 85.7 percent, responded favorably to the erythromycin-

TABLE I: DOSAGE FORM DISTRIBUTION

Age of Patients	Suspension	Chewable Tablets
0-2 years	19	0
2-5 years	24	6
5-10 years	12	23
Over 10 years	1	6
TOTALS	56	35

TABLE II: BACTERIOLOGICAL STUDIES

Organism Cultured	Number of Patients
Beta streptococci	26
Coagulase-negative staphylococci	13
Pneumococci	13
Alpha streptococci	3
Coagulase-positive staphylococci	3
No growth	5
Total number of cultures	63

TABLE III: HEMATOLOGIC STUDIES

White Cell Counts	Number of Patients
Over 10,000	59
Under 10,000	10
Total number of studies	69

TABLE IV: DIAGNOSIS AND RESPONSE TO THERAPY

Diagnosis	Number of Patients	Cured	Improved	Not Improved	Other
Pharyngitis, tonsillitis	59	39	11	3	6*
Otitis	10	5	4	1	–
Abscess	7	2	4	–	1+
Cervical adenitis	6	2	4	–	–
Bronchitis	6	2	3	1	–
Bronchopneumonia	2	1	1	–	–
Chronic rhinorrhea	1	–	–	1	–
TOTALS	91	51	27	6	7

*Medicine discontinued +Failed to return

TABLE V: CLINICAL RESPONSE

Type of Response	No. of Patients	Percent
Cured	51	56.0
Improved	27	29.7
Not improved	6	6.6
Medicine discontinued	6	6.6
Failed to return	1	1.9
TOTALS	91	100.0

TABLE VI: PATIENT RESPONSE

Patient Reaction	Suspension	Chewable Tablet
Liked very much	10	1
Liked	23	11
Accepted	14	12
Disliked	6	3
Disliked very much	2	5
Refused	1	2
Failed to return	0	1
TOTALS	56	35

sulfas combination within 72 hours. Of these, 51 children were classified as cured and 27 as improved. Only six of the patients were not improved within the specified 72 hours. Of the remaining patients, medication was discontinued in six, and one was lost to follow-up. Tables IV and V summarize the pertinent aspects of the clinical results.

Medication was discontinued in two patients because of vomiting after administration of the drug; a third patient developed hives on the fifth day of treatment. Three patients were classified as "medication discontinued" because of their refusal to accept either dosage form of the drug.

The child's reaction to the dosage form he received was rated on a scale ranging from "liked very much" through "disliked very much" to the end point of actual refusal. A total of 71 children, 78 percent of the entire series, accepted or actually liked the dosage form received. Table VI indicates the results of the ratings for each form. More than 70 percent of the children given the chewable tablet accepted it, and of these, half expressed a liking for it. Patient acceptance of the suspension form was even better; 47 of 56 children accepted the suspension; 33 liked it. Again, one reaction to medication remains undocumented because of the child's failure to return for a follow-up visit.

Discussion

The favorable clinical response of more than 85 percent of the patients in this study indicates the therapeutic value of the erythromycin-sulfas combination. This agent appears to answer several requirements:

1. Erythromycin has been shown to have bactericidal activity against the streptococcus, the pneumococcus, many strains of stapylococcus, and some strains of Hemophilus influenzae. Its spectrum of activity includes several other important pathogens also. One of these in particular, Mycoplasma pneumoniae, may prove to be a more important factor in the ill-defined upper respiratory infection than is currently realized.

2. The lack of serious toxicity of erythromycin is important. The stearate and ethyl succinate forms used in this study do not have the potential for producing cholestatic jaundice that has been observed with the estolate form[11].

3. The common triple sulfonamide combination of sulfadiazine, sulfamerazine, and sulfamethazine has an excellent record of safety, possessing, as it does, high solubility and low crystalluria potential.

4. The spectrums of erythromycin and the sulfas complement and extend each other with the least possibility of potential difficulty for the patient.

5. The degree of patient acceptance in this study 78 percent — denotes considerable success in devising palatable pediatric dosage forms. It is worth noting that this high rate of acceptance applied in the large group of children with pharyngitis and tonsillitis. This palatability adds an important dimension to the use of this drug combination in children; without such acceptability, ambulatory treatment may fail.

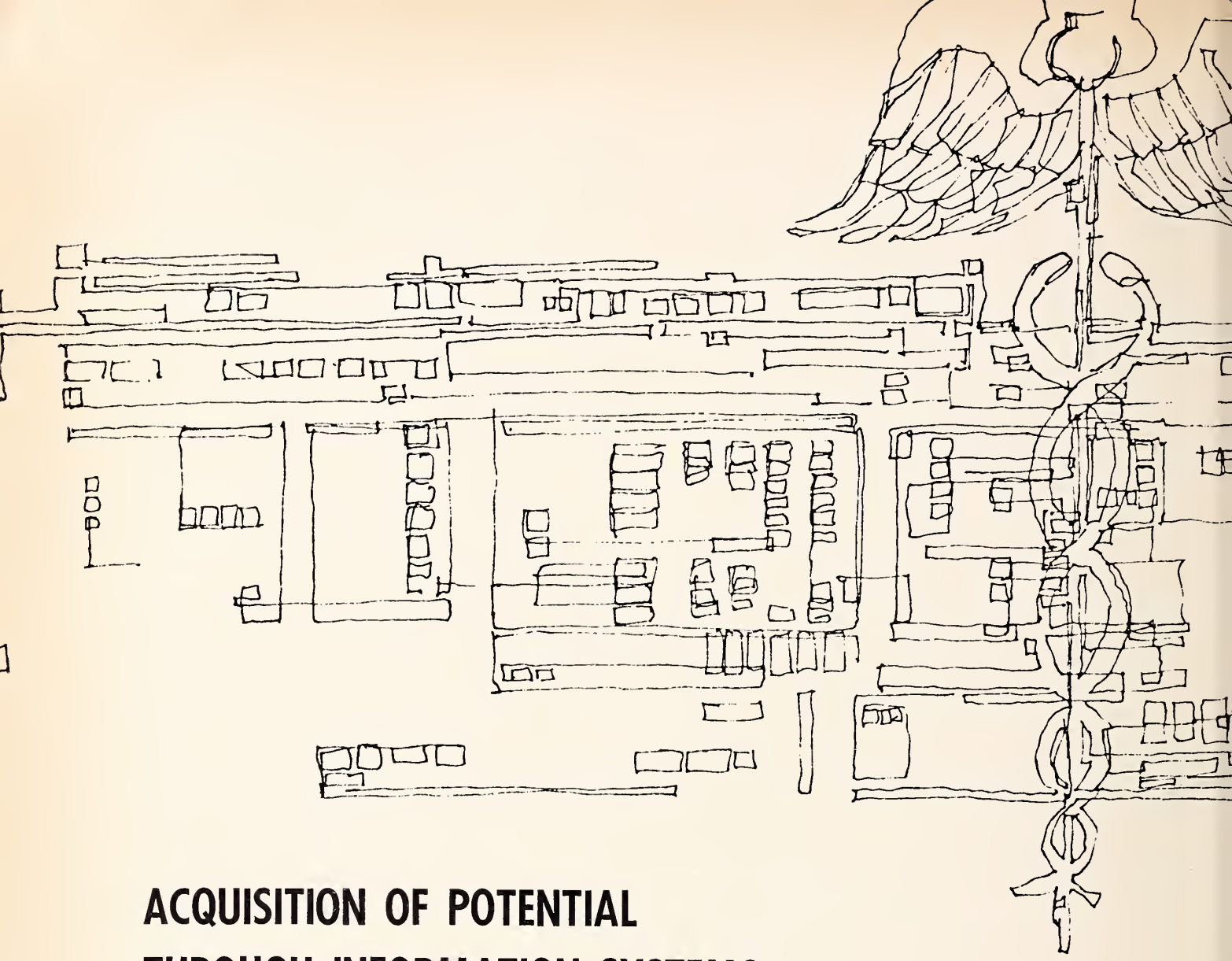
Summary and Conclusions

A newly-developed combination of erythromycin and triple sulfonamides in pediatric dosage forms has been evaluated as initial clinical therapy for bacterial infections of the respiratory tract or skin. In a series of 91 children, ranging in age from eight months to 12 years, a favorable response to therapy was obtained in 85.7 percent of the patients. Fifty-one of these children were classified as cured and 27 as significantly improved within 72 hours after the start of therapy. On this basis, it is concluded that this drug combination offers effective clinical treatment for the range of infections studied, including those caused by Group A beta-hemolytic streptococci.

Evaluation of patient reactions to the medication indicates a satisfactory degree of acceptance for both the chewable tablet and oral suspension forms of the combination.

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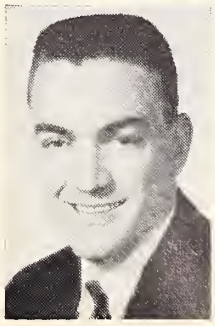
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ACQUISITION OF POTENTIAL THROUGH INFORMATION SYSTEMS



BYRON C. MOORE, Ed.D.
ARIZONA
CHILDREN'S COLONY



DAN PAYNE
WESTERN INTERSTATE
COMMISSION FOR
HIGHER EDUCATION

Terms such as "cohort," "central data bank" and "third generation computer" are more frequently heard in conversations among physicians. Use of these terms reflect increasing sophistication and an awareness that acquisition of reliable information is acquisition of potential for evaluating and planning unknown in the past. Educational management of children is no longer considered the sole province of teachers. Success of children in school is rightfully related to mental health, physical condition, social status and many other variables of inner and outer environment. Indeed, such vast amounts of pertinent multidisciplinary information are now required that the development of modern, automated information systems is virtually a necessity. Con-

ventional methods of collecting and processing information related to education are rarely adequate. This is particularly true in view of the value of information and information collection systems to communications effectiveness. Nothing can frustrate a researcher or hospital administrator more than spending months seeking solutions which have already been obtained elsewhere but not communicated.

In 1963 members of the Western Interstate Commission for Higher Education (WICHE) became concerned with this problem. The need to improve information gathering and utilization systems within educational institutions for the mentally retarded was especially acute. Promoting inter-institutional cooperation and stimulating research were seen as natural consequences of the availability of such information. A pilot program to explore the feasibility of such an information system was initiated.

This program, currently funded by the National Institute of Child Health and Human Development, has grown from uneasy involvement by a few institutions to wholehearted cooperation by nineteen institutions scattered throughout thirteen western states. Annually, these institutions record information on each individual within their populations using standard forms provided by WICHE. Upon completion, all forms are forwarded to a central location and electronically processed. Participating institutions receive information on the characteristics of the population of all institutions, as well as a detailed analysis of their own population. Special studies, such as compilations of data by residential units, have also been completed.

The population census form used to collect basic data consists of items which fall into three broad categories. The identification series provides information on admisson number, sex, age, race, religion, etiology, level of retardation and selected vital statistics. Secondly, a series of items related to institutional programs record the residents' status with regard to educational placement, vocational training, work projects, community placement and home care. The third and largest category of items describes residents in terms of physical, social and behavioral functioning. Ratings on ambulation, vision, hearing, dressing ability, communication, toilet training and grooming are obtained. A number of items in this category are geared to gain insight on the adaptive/maladaptive behavioral status of residents.

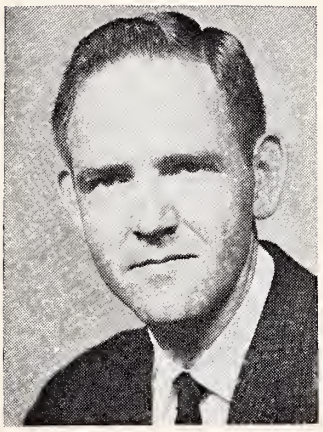
The Arizona Children's Colony is perhaps representative of institutions which have profited greatly from participation in the WICHE program. Ready access to information on its own population and sister institutions of the West has served several useful purposes. Comparison of population characteristics for each year since 1963 has illustrated important trends. For example, the mean age of residents is steadily increasing. There are a number of possible consequences for this increase, one of which relates to decreasing parental visitations. Mean levels of social and intellectual retardation are going down as mildly retarded residents are returned to home communities and replaced by more severely retarded admissions. Severely retarded persons have a high rate of additional handicaps. As a consequence, seizure disorders, orthopedic handicaps, sensory deficits, speech defects and chronic illnesses are more prevalent within the population. These trends have logical staffing, programming and budgetary implications. This knowledge has assisted the Colony staff in shifting program emphasis to meet emerging demands for service.

Each year institutions such as the Colony are bombarded with requests for information from governmental agencies, professional organizations and graduate students. Without the speed, flexibility and availability of computer processed data, many requests would remain unanswered.

As expected at the outset, the availability of this information has stimulated reasearch. To date, all Colony research has attempted to serve the dual purpose of increasing knowledge about mental retardation while solving specific local problems. Currently, research is underway on seizure-retardates, mongoloids and problems related to home and parent visitation. Each of these projects involve significant sub-populations within the Colony. Two projects are being replicated in other states. Cooperation between researchers provides stimulating interchange of ideas and strengthens study results while saving time and money.

Much progress has been made in realizing the potential of information systems by western institutions for the retarded. Certainly, few of the nineteen participating institutions could bear the expense of such a system if each stood alone.

THE LYMPHOMA SPECTRUM



ROBERT H. THOENY, M.D.

Director of Radiotherapy, Good Samaritan Hospital, Phoenix, Arizona.

Presented at the Arizona Meeting of The American College of Physicians, Tucson, December 9, 1967.

In this article attention is again called to the clinical anatomical distribution of lymphomatous disease. Early diagnosis and staging is essential since modern chemotherapy and radiotherapy techniques make cure possible for many lymphoma cases and improved palliation for others.

"Malignant lymphoma" is an American term first proposed by Billroth in 1871. It is now generally used to describe a spectrum of diseases involving mesenchymal tissue manifested by characteristic malignant changes in the lymphatic system. Many uncertainties continue to surround the lymphomas including whether they represent true neoplasia or a response to an infectious stimulus; their classification into separate disease entities or manifestations of a single underlying disease state; their unicentric or multicentric origin; and their curability or incurability. One thing seems certain, the malignant lymphomas confront the physician with a challenge unequalled by any other malignancy.

These tumors truly present many faces and it is this great diversity of clinical manifestations which is in large part responsible for the confusion surrounding the lymphomas. This paper presents an analysis of the intial clinical findings in a group of lymphoma patients seen in private practice. Several cases with unusual symptomatology are described to alert the physician to some uncommon manifestations which may be encountered with lymphomatous disease.

Analysis of Series

The case histories of an unselected group of patients with malignant lymphomas treated by radiation therapy at Good Samaritan Hospital were reviewed. Included were all patients in whom the initial clinical manifestations of the disease were observed or could be determined. There were 68 cases for analysis with the following histological classification: Hodgkin's disease 25, reticulum cell sarcoma 20, lymphosarcoma 18, and giant follicular lymphoma 5.

The initial disease sites for each type of lymphoma are given in Tables 1-4. The combined cervical-supraclavicular nodal region was the most commonly involved, being found in 68% of the Hodgkin's patients, 60% of giant follicular

HODGKIN'S DISEASE - 25 PATIENTS

Initial Manifestation of Disease -

SITE		NO. PATIENTS
CERVICAL-SUPRACLAVICULAR NODES		17
UNILATERAL	13	
BILATERAL	4	
MEDIASTINAL-HILAR NODES		6
INGUINAL NODES		6
AXILLARY NODES		5
OTHER*		8

*SPLENOMEGALY 3, ABDOMEN 2, STERNUM 2, PHARYNX 1.

TABLE 1

RETICULUM CELL SARCOMA - 20 PATIENTS

Initial Manifestations of Disease

SITE		NO. PATIENTS
CERVICAL-SUPRACLAVICULAR NODES		6
UNILATERAL	1	
BILATERAL	5	
AXILLARY NODES		6
INGUINAL NODES		4
MEDIASTINAL-HILAR NODES		0
OTHER*		12

*BONE 2, CECUM 1, PROSTATE 1, PAROTID & FACIAL SOFT TISSUES 1, PELVIS 1, PERIRENAL 1, MASTOID & BRAIN STEM 1, ABDOMINAL 2, THYROID 1, SPLENOMEGALY 1.

TABLE 2

LYMPHOSARCOMA 18 PATIENTS

Initial Manifestation of Disease

SITE		NO. PATIENTS
CERVICAL-SUPRACLAVICULAR NODES		6
UNILATERAL	4	
BILATERAL	2	
INGUINAL NODES		4
AXILLARY NODES		3
MEDIASTINAL NODES		2
OTHER*		9

*TONSILS 2, PELVIS 1, RETROPERITONEAL 1, GASTRIC 1, DUODENAL 1, CECUM 1, ORBIT 1, BLADDER 1.

TABLE 3

GIANT FOLLICULAR LYMPHOMA - 5 PATIENTS

Initial Manifestations of Disease

SITE	NO. PATIENTS
CERVICAL-SUPRACLAVICULAR NODES	3
INGUINAL NODES	1
AXILLARY NODES	1
MEDIASTINAL-HILAR NODES	0
OTHER*	4

*MANDIBULAR 1, PELVIC 1, GENERALIZED 1, SPLENOMEGALY 1.

TABLE 4

lymphoma, 33% of lymphosarcoma, and 30% of reticulum cell sarcoma. This preponderance of cervical node enlargement as a presenting symptom of lymphomas, particularly Hodgkin's disease, has been reported by other investigators. The axillary and inguinal nodes showed about equal involvement with all types of disease, which was of the same order of frequency as the cervical nodes in the lymphosarcoma and reticulum cell sarcoma groups but considerably less with Hodgkin's disease patients.

In this rather limited number of patients it is noted that those presenting initially with hilar-mediastinal nodal enlargement by x-ray were overwhelmingly in the Hodgkin's group. Two lymphosarcoma patients were the only others in the entire series who presented with this finding. The great majority of Hodgkin's patients had symptoms related to one or more of the peripheral node regions so commonly associated with the lymphomas. Patients with lymphosarcoma and reticulum cell sarcoma showed a much greater tendency toward involvement of visceral and occult nodal sites. This was found in 60% of the reticulum cell sarcoma and 50% of the lymphosarcoma patients compared to 32% with Hodgkin's disease. This dissimilarity in presenting symptoms between the Hodgkin's patients and those with other types of lymphoma tends to support the belief that Hodgkin's disease represents a separate entity from other lymphomas in terms of clinical course and prognosis. Brief case histories of several patients with unusual initial disease sites are presented in the following section.

Case Presentations

CASE 1. (S.C.H.)

The patient was a male age 45 who gave a history of vomiting becoming progressively worse over a two-month period. An upper gastrointestinal series (Fig. 1) demonstrated gastric outlet obstruction with dilatation of the stomach and retained secretions. The barium remained almost entirely within the stomach during the hour of examination. The pre-operative diagnosis was that of pyloric obstruction probably secondary to a duodenal ulcer. At surgery the gastric obstruction was found to be due to a napkin-ring type of tumor surrounding the second portion of the duodenum. Multiple grossly enlarged regional lymph nodes were noted. The pathologic diagnosis was Hodgkin's disease.

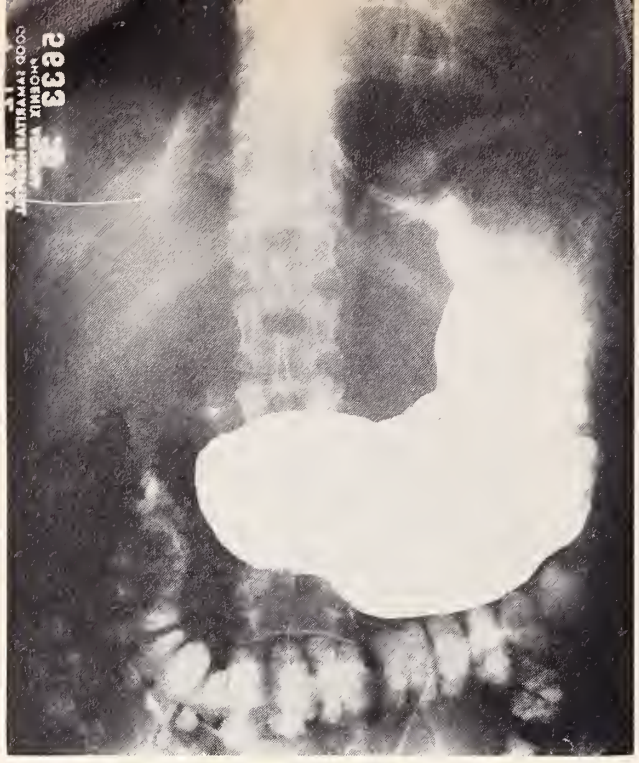


Fig. 1. Gastric outlet obstruction due to Hodgkin's disease involving the duodenum.

CASE 2. (E.T.)

The patient was a female age 71 with initial symptoms of upper abdominal pain and vomiting of two weeks duration. Upper gastrointestinal series with small bowel study (Fig. 2) showed dilatation of the upper small intestine with rigid appearing jejunal loops. Prominent edematous appearing mucosal folds were also noted in the upper jejunum. The pre-operative diagnosis was



Fig. 2. Abnormal appearing jejunal loops due to involvement by reticulum cell sarcoma.

that of some type of malabsorption state with probable bowel obstruction. At surgery a multinodular tumor mass was found involving the mesentery of the upper small intestine without true obstruction. The tumor was inoperable with penetration into the large bowel mesentery and extension into the region of the aorta, pancreas, and mesenteric arteries. The pathologic diagnosis was retroperitoneal reticulum cell sarcoma.

CASE 3. (V.B.)

The patient was a male age 51 whose initial complaint was right lower abdominal pain for 6 months. The patient had noted an enlarging mass in the abdomen for several months and this was palpable in the right lower quadrant on admission. Barium enema study (Fig. 3) revealed an irregular mass in the cecum with extension into the terminal ileum. The appearance of the lesion was thought to be compatible with adenocarcinoma of the cecum. At surgery a grapefruit sized tumor mass was present in the cecum which involved the terminal ileum as well. Numerous enlarged nymph nodes were present in the root of the mesentery and para-aortic chains. The pathologic diagnosis was reticulum cell sarcoma.



Fig. 3. Reticulum cell sarcoma involving the cecum and terminal ileum.

CASE 4. (J.D.)

The patient was a male age 69 who presented

with massive enlargement of the right parotid gland of short duration. A sialogram showed evidence of ductal ectasia compatible with inflammatory disease. Biopsy of the gland confirmed the x-ray impression. The patient was readmitted several weeks later with weight loss, fever, and increased swelling of the facial soft tissues. A submandibular node biopsy revealed necrotic tumor thought to represent reticulum cell sarcoma. This diagnosis was confirmed by subsequent inguinal node biopsy. Shortly thereafter the patient was again seen with marked swelling of the anterior facial soft tissues and films showed invasion of the anterior maxilla by adjacent soft tissue tumor. (Fig. 4)



Fig. 4. Destructive changes in the anterior maxilla due to reticulum cell sarcoma in adjacent soft tissues.

CASE 5. (M.B.)

The patient was a female age 69 who complained of pain in the neck becoming progressively worse over a one-month period. Films of the cervical spine (Fig. 5) showed destructive changes involving the second cervical vertebra. The initial impression was that of osteolytic metastasis. A needle biopsy of the involved vertebra was unsuccessful and open bone biopsy was performed. The pathologic diagnosis was reticulum cell sarcoma.



Fig. 5. Destructive changes in the second cervical vertebra due to reticulum cell sarcoma.

Summary

The initial clinical findings of a group of 68 patients with malignant lymphoma have been presented and analyzed according to disease and sites of involvement. The cervical-supraclavicular nodes were the most commonly involved especially in the Hodgkin's disease group. Patients with lymphosarcoma and reticulum cell sarcoma showed a considerable tendency to involvement of visceral and occult nodal sites. Enlargement of the mediastinal-hilar nodes was overwhelmingly due to Hodgkin's disease. Several cases with unusual findings have been presented to emphasize the spectrum of clinical manifestations these patients may present to the physician in his practice.

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President's Page



ARTHUR V. DUDLEY, JR., M.D.
PRESIDENT

Despite one of the most exerted efforts made by this Association on behalf of medical legislation we were unable to convince the Special Session of the Legislature that the UCR concept should be built into the new Industrial Commission legislation. If we won at all, we won in the fact that the bill reads that there shall be "a fee schedule set by the Commission that shall be reviewed annually."

One of the major problems encountered was a lack of statistical data. Large amounts of surgical data was obtainable from Blue Shield and made available to the various legislative committees. Unfortunately, so much of the Industrial Commission is now medically oriented the computer data from Blue Shield was not sufficient to be of any statistical value. Efforts were made over one year ago to obtain this data from HEW. Again, at the time of the Annual Meeting, the Aetna Life Insurance Company was approached and they, in turn, on your behalf, contacted Mr. Thomas M. Tierney, Director of the Bureau of Health Insurance. By letter received on June 6, 1968, Mr. Tierney informed the Association that this statistical data could not be given to any medical association or other interested parties.

The issue of usual, customary and reasonable fees with the Industrial Commission of Arizona is not dead. Through MEDICAL MEMOS and other publications of the Association we have asked each member to bill the Commission their usual and customary fee for services to patients covered under ICA. Despite the fact there is a fee schedule in existence at the present time, may I again ask each and every member to bill in his usual and customary fashion. It is only in this way that we can possibly gather sufficient data to, at some point in the future, convince either the Industrial Commission and/or the Legislature to allow the physicians of this state to be paid our usual fee unfettered by a fee schedule.

By now you are all aware that the Arizona Medical Association is planning a building and an assessment has been levied payable as $125.00 lump sum or $15.00 over a ten year period. In order to save bookkeeping expense, interest charges and all of the related expenses that go with long-term financing, may I encourage each of you who is financially able to so do to pay your $125.00 in one lump sum. Please refer to the letter that will come with your billing. This is self-explanatory.

There will be more about the progress of the building in subsequent issues of *Arizona Medicine* and through MEDICAL MEMOS. We want each and every member of this Association to participate actively in the building program.

Arthur V. Dudley, Jr., M.D.
President



THE CURRICULUM, PART I

Sooner or later the time arrives, in a new medical school, when the faculty must begin to commit itself to a structured curriculum. In ongoing medical schools, where full representation from all faculty interests and disciplines is available, curriculum matters are ordinarily resolved either by committee or by general faculty action. This process is very slow and very ponderous.

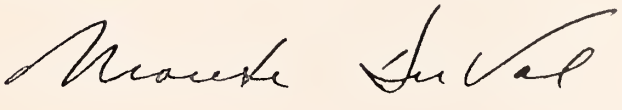
Fortunately, the new school of medicine is not burdened by such cumbersome machinery and the procedure for establishing a curriculum is much simpler. However, because all segments of the faculty are not present, the decision-making machinery is out of balance and one must, therefore, avoid making decisions that would penalize disciplines that are not yet represented in the school.

Before we started to wrestle with our curriculum we invested a great deal of time reviewing the mechanics of how best to get the widest possible exposure for all faculty views before adopting the basic precepts of the curriculum. To do this we used the technique of the "retreat." All members of the faculty were invited to live together for 48 hours at a site that was far enough away from the campus that, once there, it was impractical for them to try to continue to do any "business as usual." It worked, and the faculty came up with the ingredients of the curriculum that they wanted to adopt.

Certain points of agreement had to be reached before the curriculum specifics could be filled in. For example medical schools historically have been obligated to assure society that their graduates were ready, upon completing an internship, to compete for licensure and to practice medicine. This meant that the "core" of instructional material had to be sufficiently broad that a complete physician resulted. And although this system worked remarkably well for many years, in 1919 we began to acknowledge that additional training was definitely in order for those who wished to certify to society that they were particularly expert in one area or another of medicine. Now, 40 years later, there are 19 certifying boards covering all of the areas of specialty medicine except general practice. And now even this area is being treated as a specialty with a recommended graduate training program of its own.

In view of these developments, medical schools have been called upon to adjust their curricula to the changing needs of the graduate. In other words, the physician who limits his practice to psychiatry clearly does not need all of the same curriculum offerings as does the Ophthalmologist. And neither of these men needs the same background as the family physician.

In our Medical School, we have acknowledged these differences by cutting back the "core" of both basic science and clinical instruction to a total of 36 months. The fourth year then becomes "free." But not too free. The year will constitute a type of structured freedom within which the student can accomplish some or all of three things. First, he can use a part of that year to strengthen his competence in areas of basic and clinical science in which he has been found to be weak. Second, he can select a program that is designed to broaden his background, awareness and decision-making capability before he starts graduate work. Third, he may choose to augment his knowledge and skills in areas that are appropriate to his personal career choice. Needless to say, the manner in which the student chooses to use this fourth year will be subject to final approval by the entire faculty. (To be continued.)



Editorial

DISPOSITION OF MEDICAL RECORDS WITH RETIREMENT OR DECEASE OF A PHYSICIAN

DARWIN W. NEUBAUER, M.D.

There is neither a definite ruling nor an official policy of the AMA relating to the disposition of medical records, either for business memoranda or medical data.

The law division of AMA, under its pamphlet "Legal Aspects of Medical Records" states "there are no recorded court decisions or statutes dealing specifically with the retention of medical records when a physician dies . . . the records cannot be sold because the information they contain is confidential."

Note, however, that medical legal writers are of the opinion that medical records may be transferred to another physician who may purchase the practice and "good will" of a deceased or retired physician. They accept this as being different from purchasing the records as such. The seller should clearly notify the patients that the records will be transferred to a new physician whom the patient might designate, a step that should be done prior to the transfer to the purchaser so as to avoid a charge of solicitation.

The law does hold that the records are the property of the physician, therefore he may dispose of them as he wishes. However, the law is clear that the patient also has rights relating to the medical record as to their content in relation to diagnosis, treatment and prognosis of his physical and mental condition. The physician or his estate, therefore, has no right to dispose of the records without giving the patient a reasonable opportunity to have his new physician study them.

Further, there is the moral obligation that the physician not dispose of the records in such a way that confidential relations with the patient will be violated. There remains the basic underlying condition which must be constantly borne in mind that medical records should not be given to, nor the contents of the records revealed to, any third person without the consent of the patient.

There are other aspects that must be considered beyond the usual transfer of records, they are:

1. Records that might be pertinent to any litigation in which a patient would be involved should not be destroyed without prior notice to the patient.
2. Records that may be of value to the estate in defending any existing or potential malpractice claims should be retained until the expiration of the applicable statute of limitations.
3. Records of adult patients who have not visited the physician for more than three years may be destroyed.
4. Records of minors should be retained until these patients reach their majority or die and then for the additional period of the statute of limitations for the State.
5. Business records, which might help the phy-

sician or patient, in connection with tax returns should be retained for at least seven years.

6. In Arizona, personal injury actions or actions based upon death resulting from personal injury must be filed within two years of the date of the alleged negligent act. Contract actions must be filed within three years, actions against estates to be filed within one year.

There are several statutes of limitations that are applicable to the disposition of medical records. Legal action for personal injuries are barred after two years, and if they result in death, then two years after the date of death of the injured party. Suits on accounts receivable, however, whereby a physician might want to collect his bill, are not barred until after three years. It was a rather standard practice in some areas of this State and in California, where the same statutes apply, for physicians, lawyers, accountants, and others, to wait until the above two-year statute is past and then bring any collection actions before the three-year statute had expired. This is considered by the courts to be unfair, and there are now cases that hold that if more than one statute of limitations applies to the same set of circumstances, the longer statute is applicable to all transactions. Under those circumstances, the three-year statute very well might apply to malpractice cases, and certainly so if somebody wanted to collect a bill.

Claims against estates are required to be filed within four months of the time the executor or administrator gave notice to creditors. Unfortunately, notice to creditors is published in a newspaper like the Daily Reporter in Tucson that is read by virtually no one except lawyers, bankers and realtors.

Internal Revenue Service must make any deficiency assessments on tax returns within three years or be barred from doing so. On the other hand, agents will frequently have occasion to believe that a return should be audited and then asked the taxpayer for a waiver of the statute to give the Service time to go into it thoroughly. If the taxpayer is a little obstinate about it and refuses to waive the statute of limitations, the Service could slap a large deficiency assessment on him and let him extricate out of it as best he can. Obviously, all this controversy can go on for years. Therefore, business records should be kept longer than the three-year peiod.

The statute of limitations on accounting between partners is four years in Arizona. Partners, or even alleged or self-appointed partners, may raise this question.

These multiple recommendations and varying statutes of limitations make it obvious that GOOD medical and business memoranda be retained and that if any question does exist, consult your lawyer for advice.

SHOULD THE FDA CONTROL MEDICAL SERVICES?

"Health professionals favor a detailed study"

ARTHUR BEALL JR., M.D.

PRESIDENT, ASSOCIATION FOR THE
ADVANCEMENT OF MEDICAL INSTRUMENTATION

The recent, rapid advances in medical instruments and devices have given this equipment an increasingly important role in providing health care. But as is inevitable in any field in which progress is so rapid, problems have developed.

The vast majority of these problems do not relate to the safety, reliability, or effectiveness of devices, but to differences in terminology, to lack of compatibility, and to what might be called the state of the art. Two examples of terminology problems are the size designations of artificial heart valves — different for each manufacturer — and test loads used for reporting output of cardiac pacemakers — 300, 500, or 1,000Ω. Such problems are common in any developing field.

Similarly, compatibility of different manufacturers' products will come only after the industry has resolved many technical difficulties. Today, for example, jacks on pacemaker leads cannot be attached to pulse generators that are made by different manufacturers. This drawback relates largely to the current state of the art. In other words, additional experience must be gained before we know which type of connection is the safest, most reliable, and most effective. This cannot be accomplished by Federal edict. Ironically, one important area of incompatibility that might be solved by federal decree, that involving different patient lead cables for attachment to various makes of monitoring equipment, is totally excluded from FDA's bill.

Many professional and trade organizations recognize these problems and are trying to solve them. The Association for the Advancement of Medical Instrumentation's standards committee, for example, now is attempting to identify the various groups working in the area of standards for medical devices and learn what they have accomplished. This basic information is not now available, and it must be compiled and evaluated before any rational legislation can be enacted.

The crux of the matter of legislation is, "How serious are the problems, and what is the best way to solve them?" Do these problems really relate primarily to safety, reliability, and effectiveness, as some would lead us to believe, or to a rapidly advancing field in which the state of the art is changing daily? I admit I do not have all the answers. Perhaps the easiest solution would be to let the FDA worry about these problems and solve them for us. This might be the easiest remedy, but I remain to be convinced that it will be the best for proper patient care.

I have discussed the situation with physicians, engineers, lawyers, members of the device industry, and FDA officials. Several facts have become apparent: First, the need for blanket federal control has not been clearly established; Second, there is inadequate information available on what has been done and what is now being done in the area of standards on which to base effective mechanisms for federal standard-setting authority; Third, health professionals have already told the FDA that overzealous regulation of devices might restrict their ability to provide the best possible health care. These fears were inadequately considered when the Medical Device Safety Act was prepared. Finally, the health professions appear to overwhelmingly support the idea of setting up a national devices study commission. Many professional organizations already are on public record endorsing such a study.

No one questions the motives of individuals currently in the FDA. Times change, though, and the proposed legislation must be evaluated in the

light of the activities that it makes possible, not by how it would be implemented by specific individuals. The health professions and industry are concerned, and rightly so, that the Medical Device Safety Act could allow many safe, reliable, and effective devices to be removed from the market, and prevent others from becoming available.

Future of Devices is at Stake

While the FDA-backed bill provides for an independent advisory committee to help resolve issues, this consultation is not required by the bill. Furthermore, although the producer of a device that is adversely affected by a regulation may request a consultation with an advisory committee, the manufacturer can be required to pay in advance all expenses the referral would involve. A crucial point here is that the yearly market for some lifesaving devices does not justify such expenditures. The obvious result: Many important devices may no longer be available.

Moreover, even if a currently available device is exempt from pre-market clearance because it is recognized by experts as safe, reliable, and effective, what if it can be improved? If it is an implantable device, does the change in construction for the improvement then subject it to preclearance? Consider the manufacturer's expense: Will he then not be reluctant to improve his devices?

I would prefer to have all these potential problems eliminated in the specific language of the legislation that is finally enacted. Meanwhile, in such a complicated situation, I urge that a careful and specific diagnosis be made, perhaps by a national device commission, before potentially dangerous therapy is instituted.

Source: MEDICAL-SURGICAL REVIEW, a Chapman-Rheinhold publication.

Letters to Editor

June 11, 1968

Roland F. Schoen, M.D.
Editor-in-Chief
Arizona Medicine
1023 E. Florence Blvd.
Casa Grande, Arizona

Dear Rollie:

I feel I must write to you with regards to and in rebuttal to the rambling, poorly written and offensive editorial by Clifford L. Kline, M.D. appearing in the May 1968 Arizona Medicine.

At this time we certainly do not need devisiveness in organized medicine. I further resent, as a general practitioner, the inference of my peers considering me a "cross between an osteopath and a complete idiot."

If Dr. Kline is familiar with the Millis report, he would know that our country needs more general practitioners rather than less. Further, it is recognized by specialty societies that the American Academy of General Practice is striving to upgrade general practice and in this has been exceedingly successful. Further verification of this is the establishment of Departments of Family Medicine by ten medical schools so far.

I hope further editorials are stimulating — intellectually.

Sincerely yours,

James E. Brady, Jr., M.D.

In Memoriam

Frederick Theodore Fahlen, Sr., M.D.
1882-1968

Death due to rupture of an abdominal aneurysm came to "Fritz" Fahlen, Sr. at the age of eighty-six, on May 14, 1968, thus closing the career of one of the most able, personable and learned men in the annals of medicine in Arizona.

He was born in Memphis, Tennessee, on April 9, 1882. His father, a tradesman, had emigrated from Germany. Young Fahlen was attracted to medicine by his interest in anatomy but his earlier loves were automobiles, hunting and fishing. He received his M.D. degree from the Washington University School of Medicine (St. Louis) in 1903, when he was twenty-one years of age and he served as Student Instructor in Pathology in 1902-3-4. His clinical appointments during a period of fourteen years in St. Louis included: Chief of Clinic and Laboratory (1904-1914) and Chief of Medicine (1909-1918) of St. Louis Mullanphy Hospital; Instructor (1906-1912), Assistant Professor (1912-1918) in the Department of Medicine of Washington University School of Medicine; and a member of the Visiting Staff of the St. Louis City Hospital (1914-1918).

Doctor Fahlen served on the Committee on Microscopy and Pathology of the St. Louis Medical Society of Missouri as early as 1907, and, in the same year, published his classic work on "Heart Block: Its Relation to the Study of the Heart's Action" in the St. Louis Medical Review. His "The Cardiac Neuroses" and "Organic Heart Disease in its Relation to Heart Block" appeared in the Bulletin of the St. Louis Medical Society in 1908 and 1912, respectively. By the age of thirty, under the tutelage of Doctor George Dock, Professor of Medicine at the medical school, he became recognized as a rising young cardiologist and one of the pioneers in a new specialty.

He was appointed by the Surgeon General to serve on the Medical Advisory Board for the local Exemption Boards in St. Louis in 1917 but joined Base Hospital Unit 21 which was largely recruited from the Washington University Medical School in 1918. While at Camp Pike in Little Rock, Askansas, with this Unit, Doctor Fahlen had a pulmonary hemorrhage and a diagnosis of tuberculosis was established. Following two months of hospitalization in St. Louis, he and his family moved to Phoenix, Arizona. His son recalls that he studied while in bed and was able to pass the written examination for medical licensure in Arizona on April 30, 1918. He spent the remainder of the year in convalescence in Phoenix and then went to the New Mexico Cottage Sanitarium in Silver City, New Mexico to complete his "cure" during 1919.

Doctor Dock wrote from Washington University on January 6, 1920, to accept his resignation from the faculty of the medical school with these expressions: — "with great regret and with the specific understanding that as soon as you come back you are to have your old title and all the opportunities we can offer. I hope you have been well since I last heard from you. I do not believe I congratulated you on the prize you got for painting" —. Oil painting had started as a hobby while he was ill in St. Louis and was continued in Arizona and New Mexico during the next several years. He spent three months at the South West Art Center in Taos. His oil painting landscape "Taos Mountains" was awarded First Prize at the Art Exhibition of the Arizona State Fair in 1919 and his "North Side of Camelback" received Honorable Mention at the same Exhibit in 1920.

Following his recovery, Doctor Fahlen was selected as Medical Director of the New Mexico Cottage Sanitarium where he served for three years (1920-1923). This experience led to two excellent publications, — "Some Factors in Tuberculosis" (J. Mo. State Med. Assoc., December, 1921) and "A Report of Twenty Years' Work in the Treatment of Tuberculosis at the New Mexico Cottage Sanitarium, with an Estimation of the Part Played by Climate" (with E. S. Bullock in Amer. Rev. of Tuberculosis, August, 1922).

Governor Hunt appointed Doctor Fahlen as Superintendent of Public Health for the State of Arizona in 1923, and he served well for six years. The Governor cited him for introducing a Division of Vital Statistics and for carrying out

measures which were credited with preventing an epidemic of hoof and mouth disease from entering the State. During his first year in office, he filed an affidavit that a patient was insane. A Lunacy Commission later found the patient to be of sound mind and the patient claimed $25,000 in damages. Judge Dudley Windes brought the action to an abrupt halt when he ordered a directed verdict in favor of Doctor Fahlen. He published his "Myocardial Degeneration" in Southwestern Medicine in August, 1924.

After 1929, he resumed private practice. His friend and preceptor, Doctor Dock of St. Louis, recommended Doctor Fahlen for election as a Fellow in the American College of Physicians in 1931, with these words: — "I consider him one of the most brilliant graduates that our Washington University School of Medicine has graduated since my connection with this institution." His "Pathology of Pulmonary Tuberculosis, its Relationship to Clinical Manifestations, Course and Therapeutics" appeared in Southwestern Medicine in September, 1934. The Maricopa County Medical Society elected him as its President in 1935 and later gave him a Distinguished Service Award. The Arizona Medical Association honored Doctor and Mrs. Fahlen at its annual meeting in 1953, when Doctor Fahlen was inducted into the Fifty Year Club "upon completion of his first fifty years of practice." The University of Arizona conferred its Medallion of Merit to him on the occasion of the Seventy-fifth Anniversary of the founding of the University in 1963.

To his family, he was the beloved husband and father, a person interested in their lives and their needs. His widow, Olive Cuthbert, whom he married on October 10, 1906, remembers him as the beloved, educated physician whose devotion and dedication to his patients was completely unselfish. His gun collection, hunting, fishing, tinkering wth automobiles and painting all delighted him and those about him. He leaves three children, Mrs. A. R. Campbell of Phoenix, F. T. Fahlen, Jr., Vice President of Arizona Public Service and Doctor Charles C. Fahlen, Family Physician of San Francisco. "Fritz" Fahlen's legacy is rich indeed and sets an example for the best in medicine and humanism, a real measure of man's immortality.

John R. Green, M.D.

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Future Medical Meetings

SYMPOSIUM ON VIRUS DISEASES

September 28-29, 1968

Del Webb's TowneHouse
Phoenix, Arizona

Sponsored by

The Arizona Chapter of the American Academy of Pediatrics
and
The National Communicable Disease Center

GUEST SPEAKERS

Charles A. Alford, Jr., M.D.,
Professor Pediatrics
U. of Alabama Medical School

Max D. Cooper, M.D.,
Professor Pediatrics
U. of Alabama Medical School

Henry G. Cramblett, M.D.,
Professor and Chairman
Dept. Medical Microbiology
Ohio State Medical College

Harris D. Riley, Jr., M.D.,
Professor Pediatrics
Children's Memorial Hospital
U. of Oklahoma Medical Center

Joseph W. St. Geme, Jr., M.D.,
Professor Pediatrics
UCLA School of Medicine
Harber General Hospital,
Torrance, California

FOR ADDITIONAL INFORMATION CONTACT:
Melvin L. Cohen, M.D.,
Dept. Pediatrics
St. Joseph's Hospital
P. O. Box 2071, Phoenix, Arizona

CLINICAL NUTRITION PROGRAM

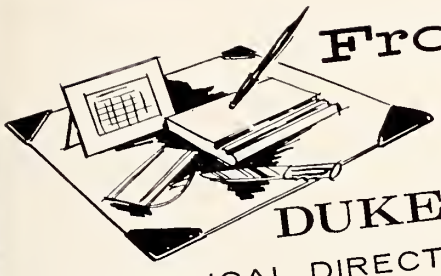
The Arizona Medical Association, in co-operation with the A.M.A. is co-sponsoring clinical lectures in two universities in Arizona during the 1968/9 academic year. The A.M.A. Council on Foods and nutrition initiated the Clinical Nutrition Program in the fall of 1964. It is being carried out on a regional basis with several distinguished lecturers participating.

The lectures are designed to stimulate undergraduate students to consider careers in the health sciences, as well as to inform the audience of recent developments in the field of nutrition.

Dr. Ernest Beutler, Chairman, Division of Medicine and Director, Department of Hematology at the City of Hope Medical Center, Duarte, California, will speak on "The Effects of Iron Deficiency and Iron Excess" at the following schools:

University of Arizona, Tucson
Wednesday, October 16, 1968
7:30 P.M.

Northern Arizona University in Flagstaff
Thursday, October 17, 1968
7:00 P.M.



From The Desk Of

DUKE GASKINS, M.D.

MEDICAL DIRECTOR, HBA LIFE INSURANCE CO.

Doctor:

Let's get one thing straight –

HBA's schedule of surgical benefits, while quite generous, in no way, and we repeat, in no way, attempts to set your fee.

It simply states what HBA will pay for a given surgical procedure. It is a necessary tool for the company in order to provide specific benefits.

But your fee, doctor, is between you and your patient.

Thanks,

Duke

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For additional information, please contact: Alexander C. Walker, Regional Technical Representative, Geigy Pharmaceuticals, 1371 North 44th Street, Phoenix, Arizona 85008, Phone: (602) 275-7088

SPEC-2

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Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low

The therapeutic action is smooth, and persists for a full 24 hours With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

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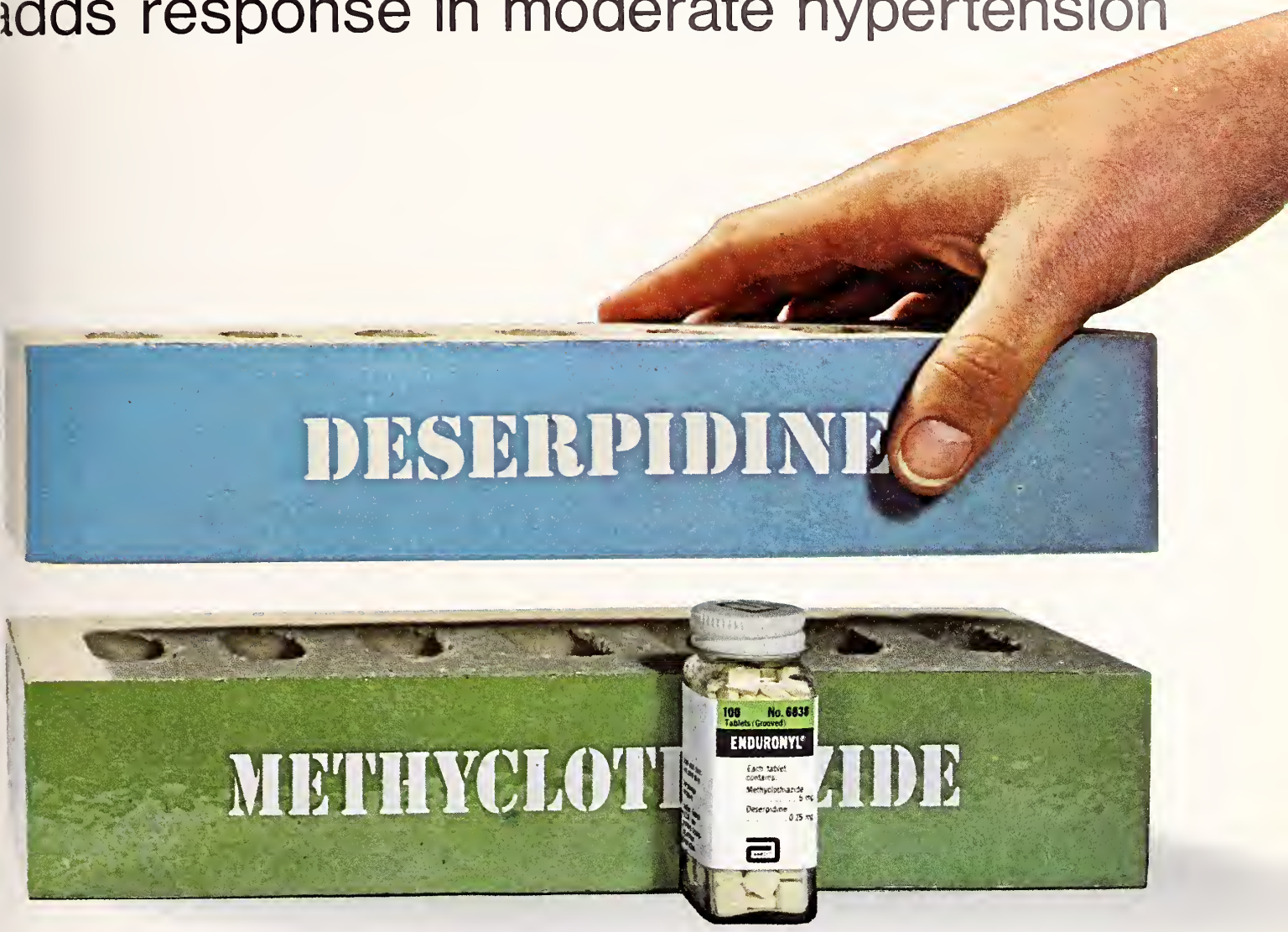
METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

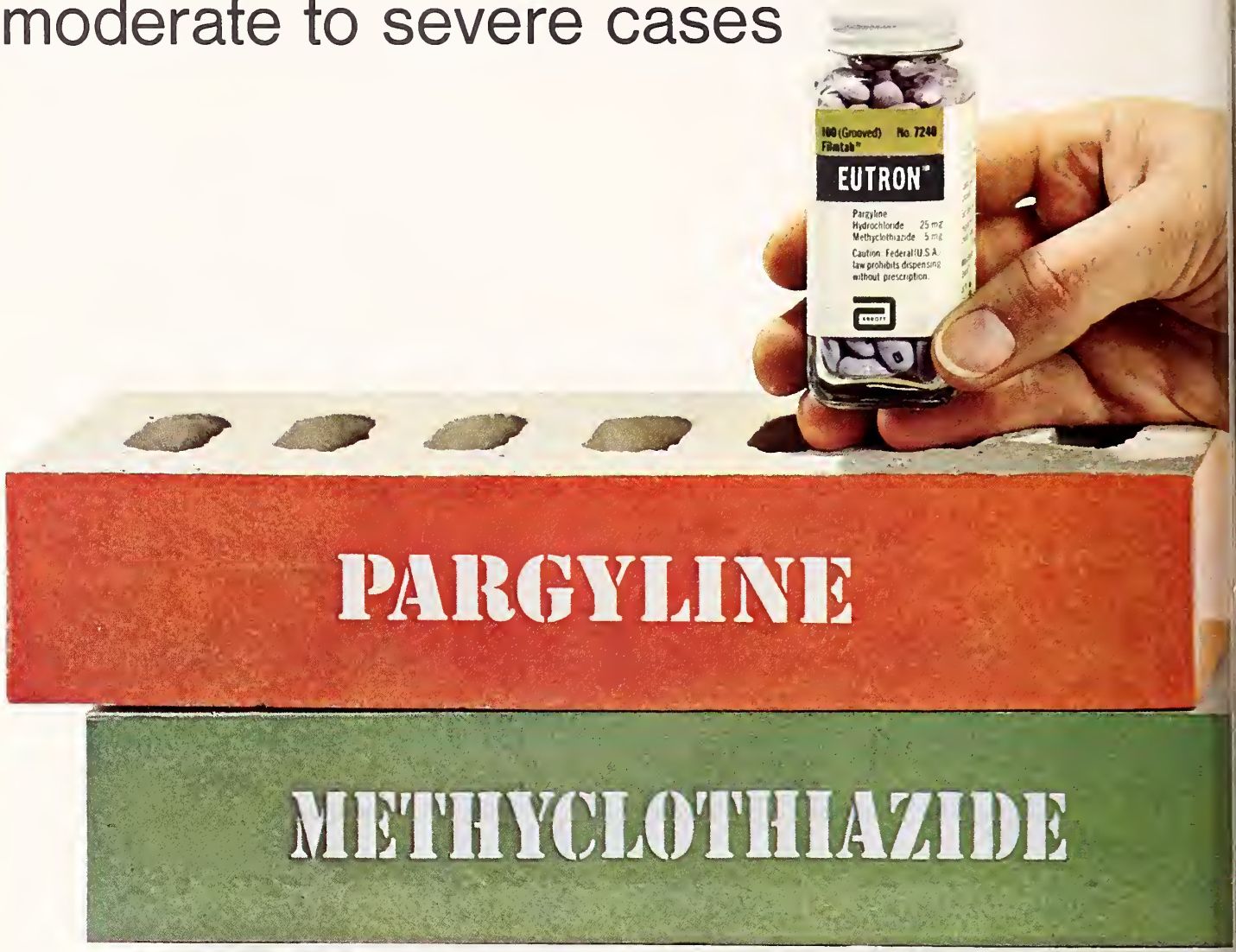
ENDURONYL®

METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.



See Brief Summary on final page of advertisement

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

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PARGYLINE HYDROCHLORIDE 25 mg.
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MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

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Each tablet contains Methyclothiazide 5 mg. with Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804439R

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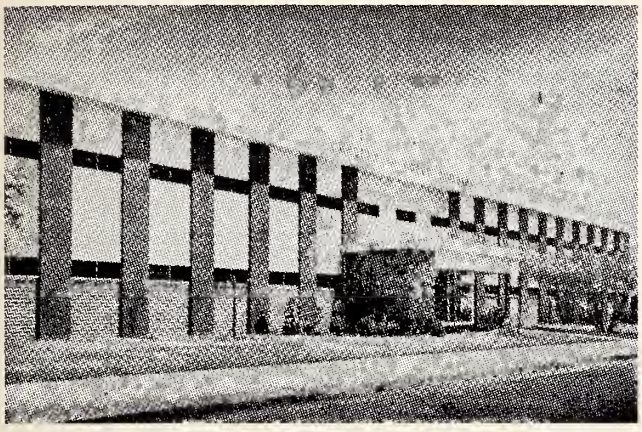
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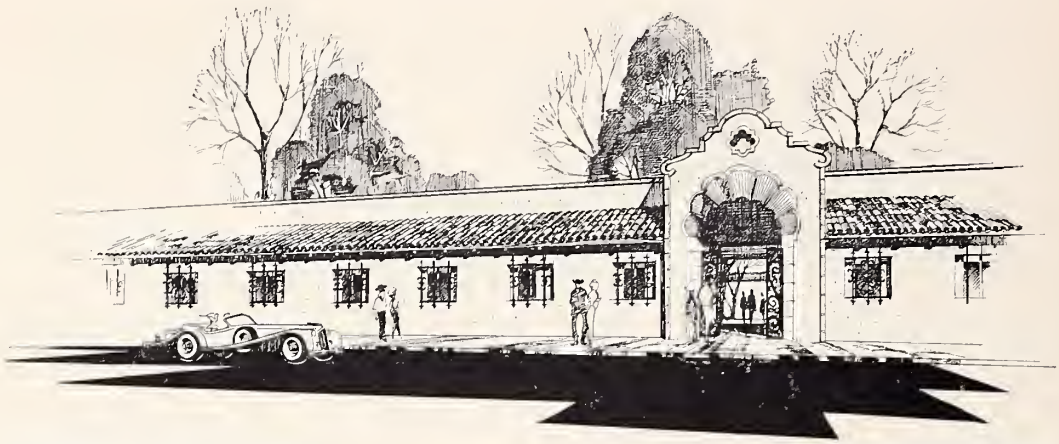


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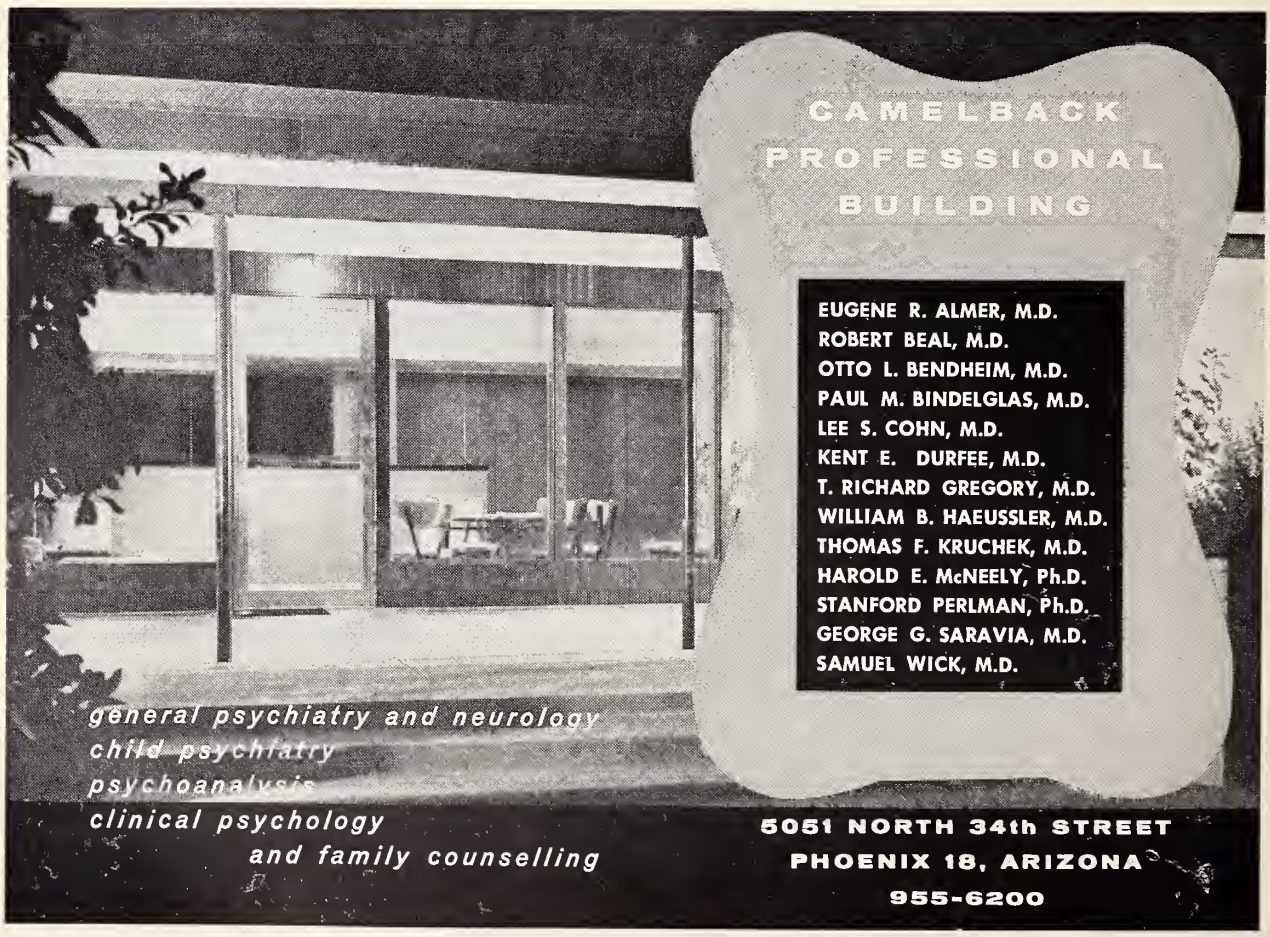
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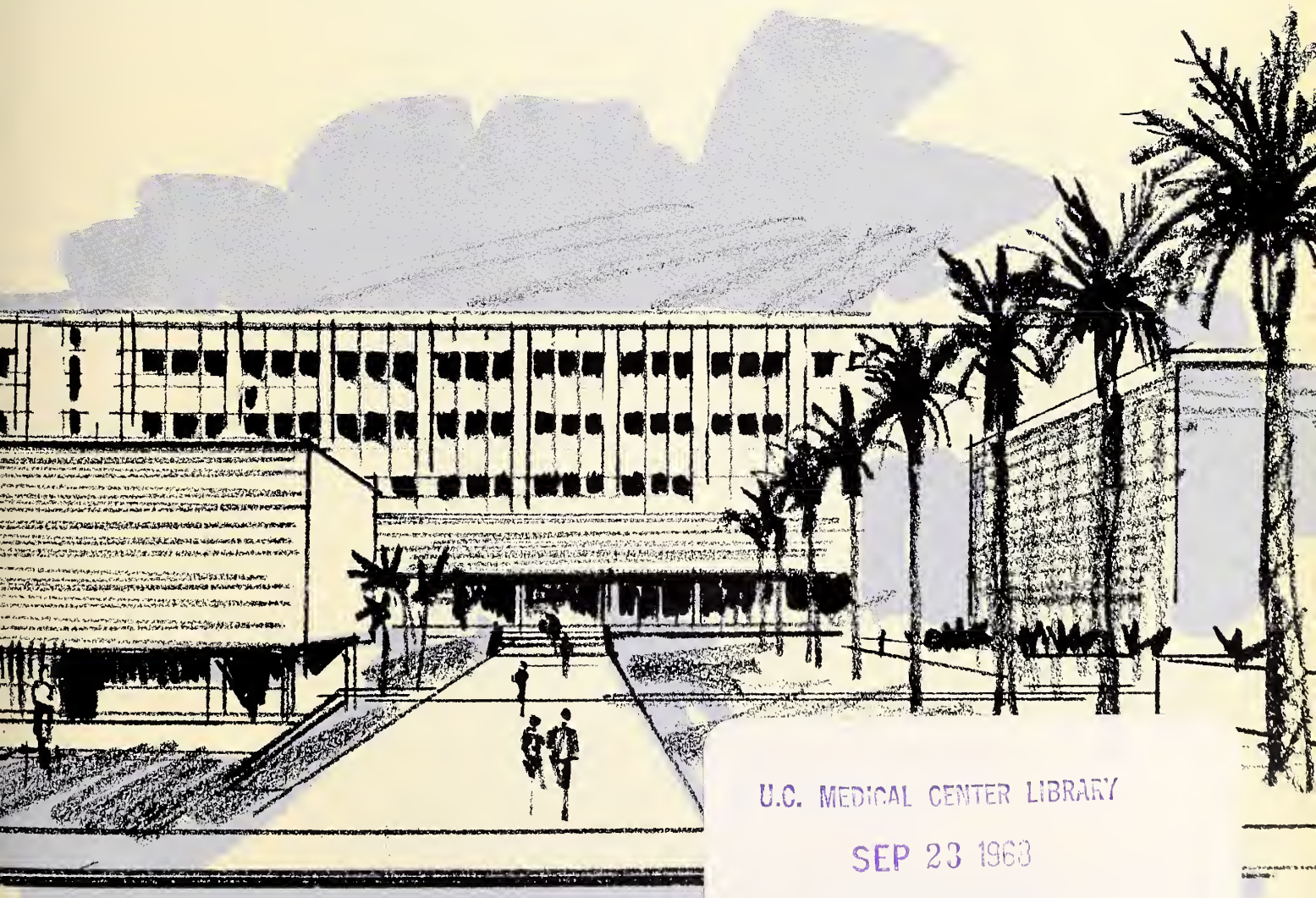
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Side Effects: Skin rash; gastrointestinal disturbances (chiefly nausea), weakness, dizziness. These seldom require cessation of therapy, and can be relieved by reducing dosage or correcting electrolyte imbalance.
Warning: Enteric coated potassium tablets have been implicated in small bowel lesions and should be used only when adequate dietary supplementation is not practical.

Lederle LEDERLE LABORATORIES • A Division of American Cyanamid Company, Pearl River, New York 10965

*Reg. U.S. Pat. Off.

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SEPTEMBER 1968/VOL. 25 NO. 9

ARIZONA MEDICINE

JOURNAL OF ARIZONA MEDICAL ASSOCIATION • MEDICAL SOCIETY OF THE UNITED STATES AND MEXICO

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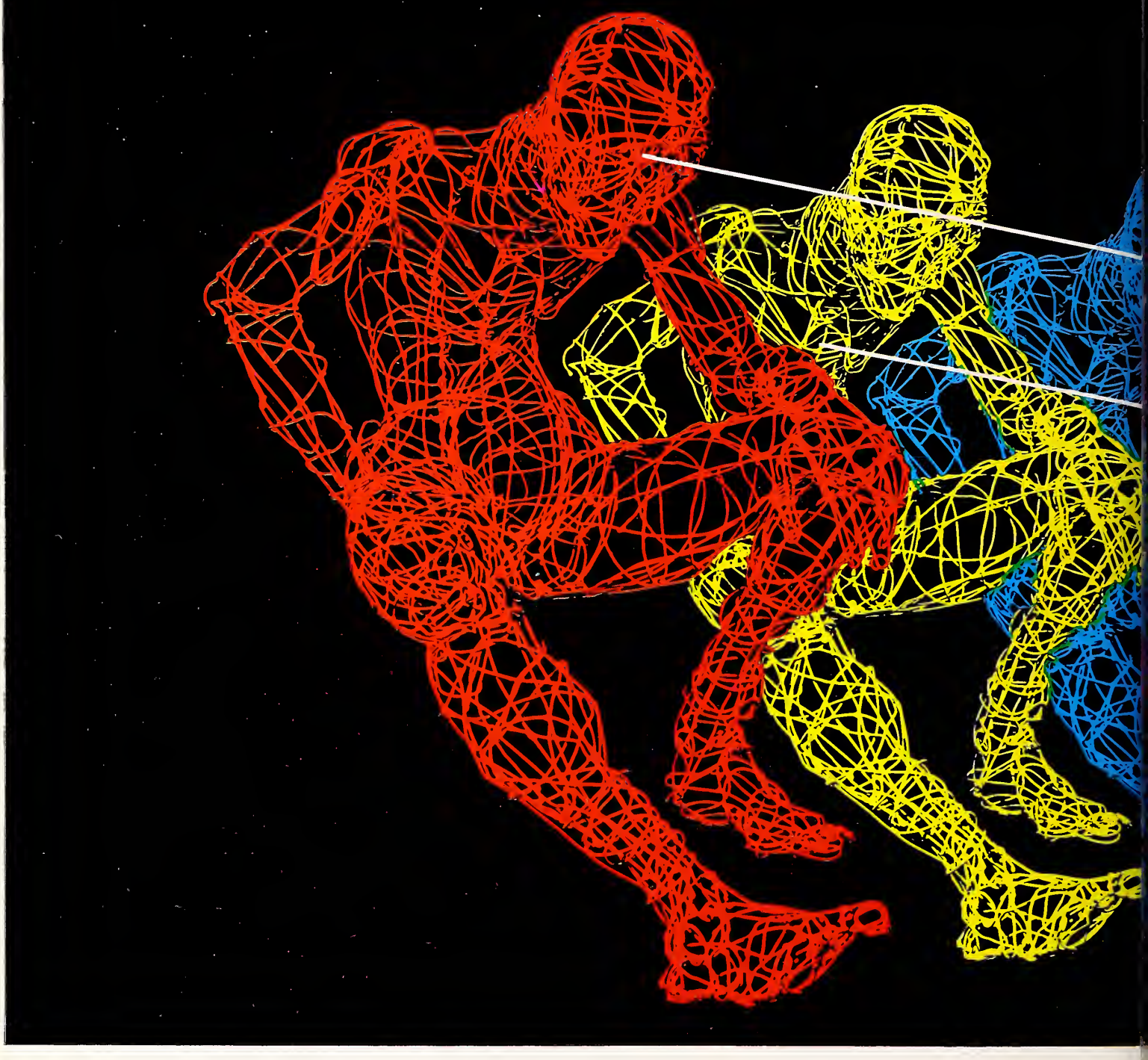
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a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropri investigation to determine its cause or causes.

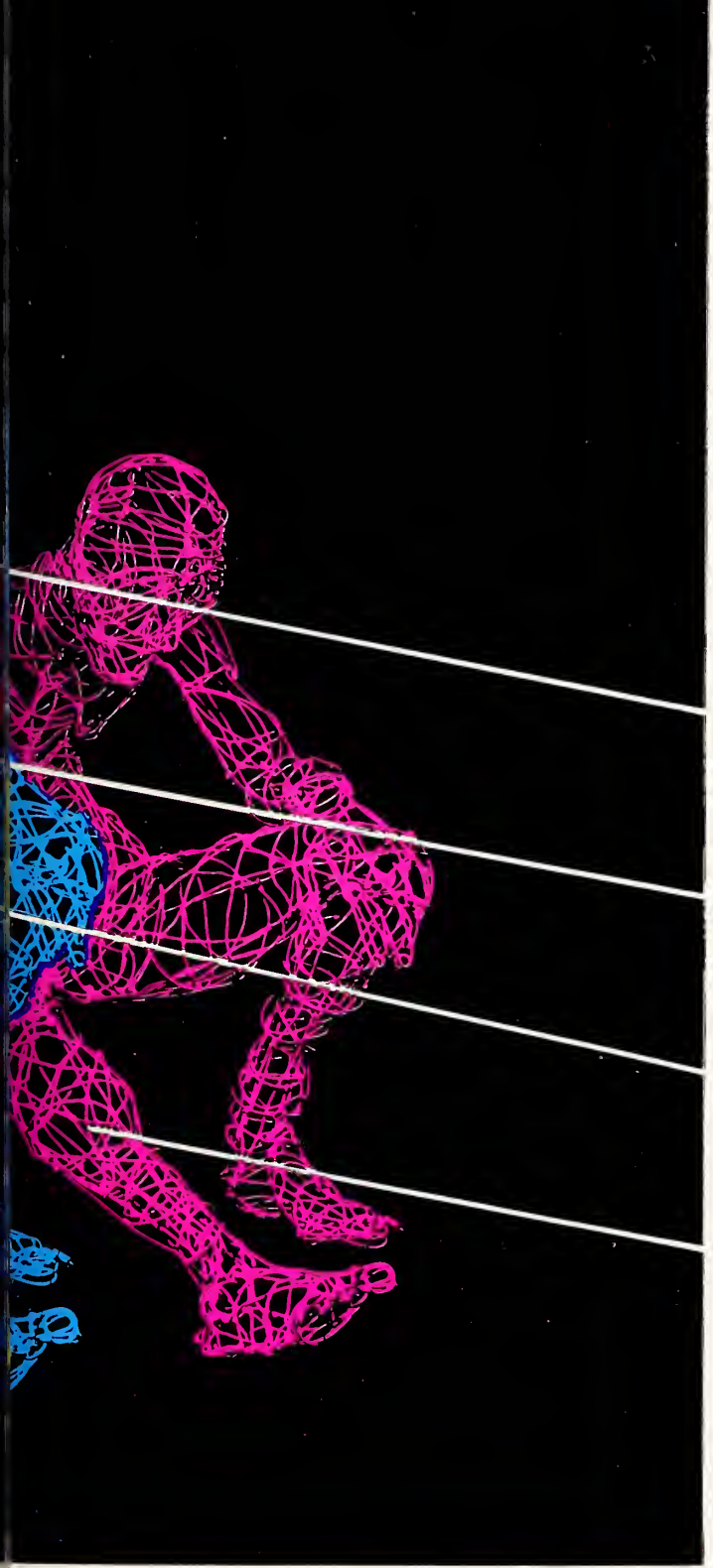
In pernicious anemia, the use of folic acid without adequa vitamin B_{12} therapy may result in hematologic remission but ne rological progression. Adequate doses of vitamin B_{12} (parenter or oral with potent intrinsic factor as in Trinsicon® [hematir concentrate with intrinsic factor, Lilly]) usually prevent, halt, improve the neurological changes.

As with all preparations containing intrinsic factor, resistan may develop in some cases of pernicious anemia to the potent tion of absorption of physiological doses of vitamin B_{12}. If resi ance occurs, parenteral therapy, or oral therapy with so-call massive doses of vitamin B_{12}, may be necessary. No single re men fits all cases, and the status of the patient observed follow-up is the final criterion for adequacy of therapy. Perio

You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic



Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

nical and laboratory studies are considered essential and are ommended.

verse Reactions: In rare instances, iron in therapeutic doses duces gastro-intestinal reactions, such as diarrhea or consti- ion. Reducing the dose and administering it with meals will nimize these effects.

n extremely rare instances, skin rash suggesting allergy has owed oral administration of liver-stomach material. Instances apparent allergic sensitization have also been reported after l administration of folic acid.

sage: One Pulvule twice a day. (Two Pulvules daily produce a ndard response in the average uncomplicated case of perni- us anemia.)

w Supplied: Pulvules Trinsicon® (hematinic concentrate with insic factor, Lilly), in bottles of 60 and 500. [032568]

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Eli Lilly and Company, Indianapolis, Indiana 46206.

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tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

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Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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Editor's Page

COMMUNICATION - REPRESENTATION

Communication is our business. A lack of communication is cause for our concern. We were concerned at the reports included in the Board of Directors' Meeting July 14th and wondered what had happened. These are the facts relative to the New Building Program as regards communication:

ARIZONA MEDICINE — three issues carried full reports in either committee or Board of Director reports or individual articles.

MEDICAL MEMOS — three issues carried reports. One issue was devoted entirely to the project.

There were three special mailings to all officers, delegates, and directors preceding the Board of Directors' Meetings and Annual Meetings.

And so ad infinitum.

What happened? Communications appeared to have broken down, but at the level of the various County Societies (presuming that everyone had read the various mailings). Research of the Bylaws of the various County Societies on record at the Central Office were read and some illuminating facts gleaned, to-wit: No two County Societies have Annual meetings within three weeks of one another; in no County Society is actual provision made for a delegate's report of business conducted at the Annual Meeting; and no County Society formally includes or provides for elected directors in any of their important legislative, executive, or steering committees.

This is still no excuse. As an educated guess, we feel that communication was lost somewhere between "File 13" and County Medical Society Meetings.

Communications and representation must be a bilateral responsibility. Information dispersed but unread is useless. Uninformed and uninstructed representatives or delegates cannot do the business required of a constituency, and then obviously neither representation nor communication exists, and we reap the recriminations which later we regret.

In a rapidly changing and sophisticated age of medicine, ARIZONA MEDICINE calls for a review and revision of all current County Medical Society Bylaws so that communication and representation may again become a fact.

Roland F. Schoen, M.D.
Editor



No one should be cold on a Caribbean cruise

To those with peripheral vascular disease, a balmy ocean breeze can become a limb-chilling wind . . . a stroll on the deck a painful, stop-and-go chore.

Priscoline can help. It dilates peripheral blood vessels, increases blood flow to extremities. Relieves numbness. Makes hands and feet less prone to chill. Makes patients more comfortable. Helps them get around.

Nothing magic about Priscoline. But people with peripheral vascular disease might think so.

See following page for prescribing information.

Priscoline®

(tolazoline)
peripheral vasodilator

CIBA

2/3851

Priscoline®
hydrochloride
(tolazoline hydrochloride)



Indications Spastic peripheral vascular disorders.

Precautions Tolazoline stimulates gastric activity and increases hydrochloric acid content of the stomach; use cautiously in patients with gastritis or peptic ulcer or in those with suspected peptic ulcer. Give cautiously, if at all, to patients with known or suspected coronary artery disease.

Adverse Reactions Occasional: nausea, epigastric discomfort, tachycardia, flushing, slight rise or fall in blood pressure, increased pilomotor activity with tingling or chilliness. Rare: vomiting, diarrhea. Symptoms are generally mild and frequently disappear with continued therapy, regardless of dosage.

Administration and Dosage Careful individualization of dosage is required.

Oral *Tablets:* Usually 25 mg 4 to 6 times daily is sufficient. If necessary, dosage may be increased gradually up to 50 mg 6 times daily.

Lantabs: Generally, 1 Lontab every 12 hours will achieve the same effect as one 25-mg regular tablet every 4 hours (6 times a day). Thus, continuous action throughout the night is achieved without the need for arising to take additional medication.

Parenteral *Subcutaneously, Intramuscularly, or Intravenously:* 10 to 50 mg 4 times daily. Start with low doses, increasing with patient under close observation until optimal dosage (as determined by appearance of flushing) is established. Keeping patient warm will often increase effectiveness of drug.

Supplied *Tablets,* 25 mg (white, scored); bottles of 100 and 1000. *Lantabs,* 80 mg (bright yellow); bottles of 100. *Multiple-dose Vials,* 10 ml, each ml containing 25 mg tolazoline hydrochloride, 0.65% sodium citrate, 0.65% tartaric acid, and 0.5% chlorobutanol as preservative in water; cartons of 1.

Lontabs® (long-acting tablets CIBA)

Consult complete literature before prescribing. 2/3851

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Blessed event?

Not entirely, when nausea and vomiting occur in early pregnancy. Emetrol offers prompt and safe relief. Local rather than systemic action provides emesis control on contact with the hyperactive G.I. tract.* In a study of 123 pregnant women, the drug produced measurable improvement in 79% of patients in controlling vomiting.[1]

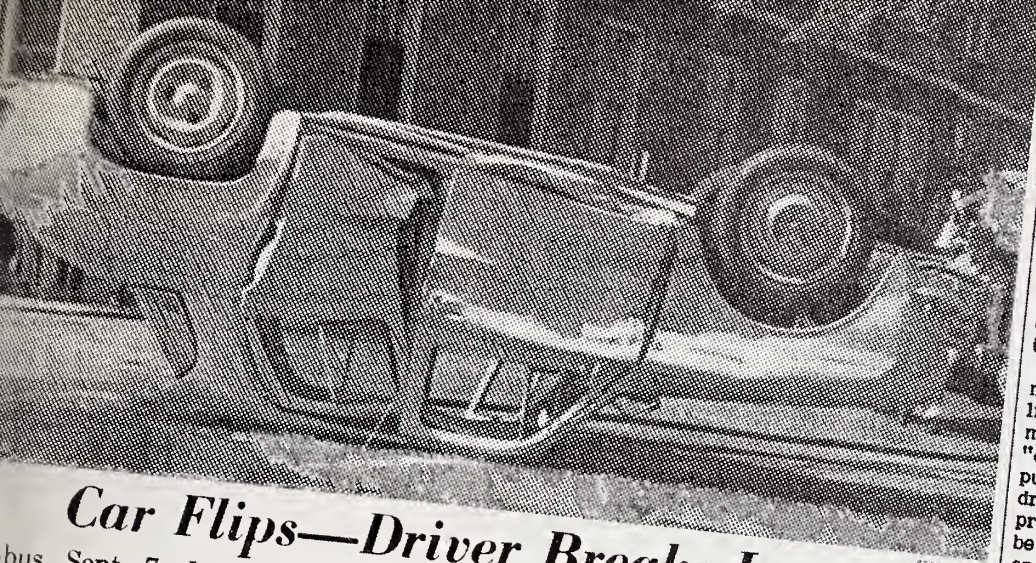
*As shown by *in vitro* studies.

1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



Emetrol®
phosphorated carbohydrate solution
emesis control

ROHER WILLIAM H. RORER, INC.
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Car Flips—Driver Breaks Leg

bus, Sept. 7. John P. Jones of Lane incurred a broken leg today he was driving failed

Patrolman B. R. Brown, the car hit a fire hydrant and flipped over on its top. Hasn't he had enou[illegible]

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He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic 1/4 grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

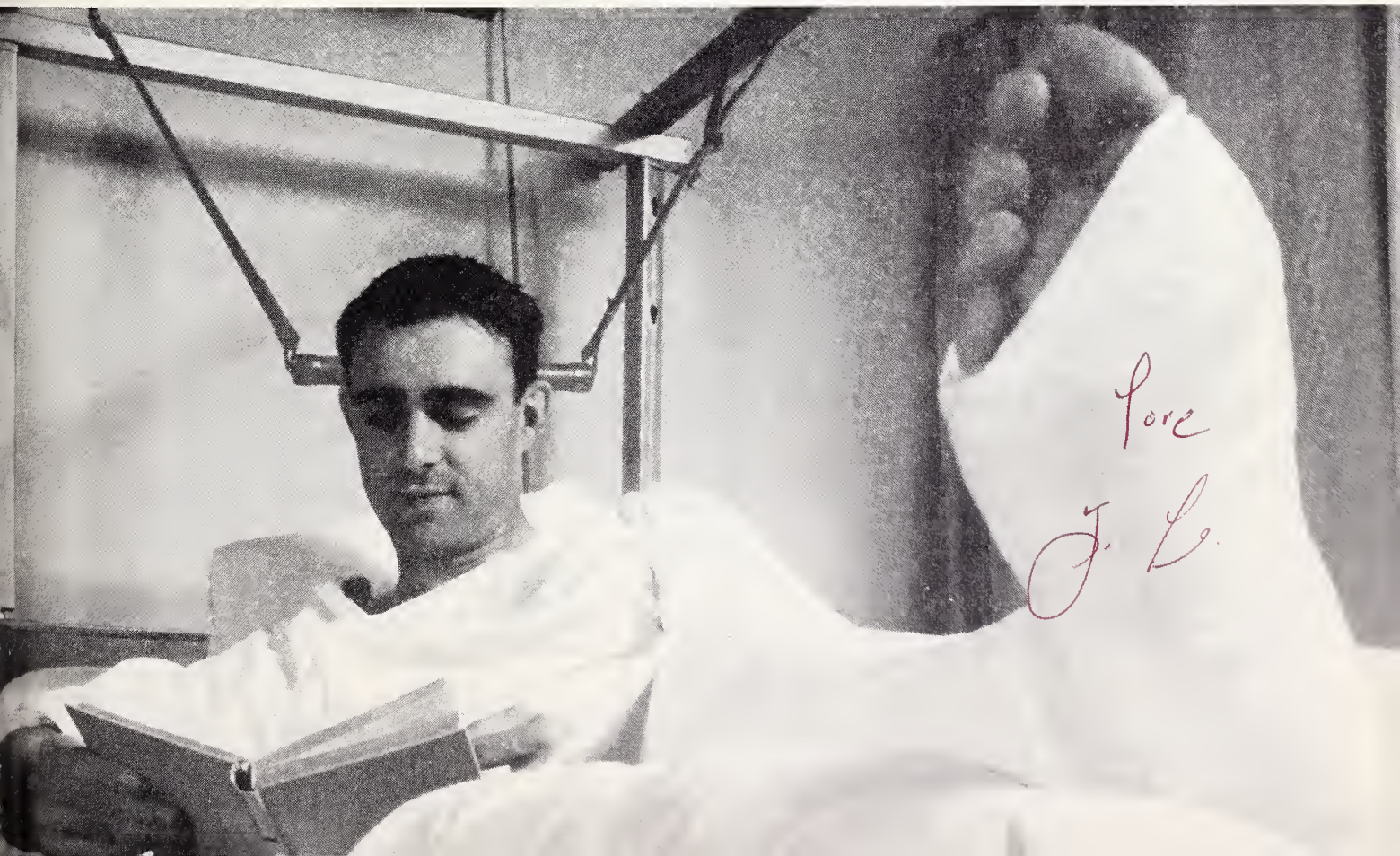
Phenaphen® with Codeine

Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (1/4 gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2 1/2 gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, 1/4 gr. (No. 2), 1/2 gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A. H. ROBINS COMPANY
RICHMOND, VA. 23220 A·H·ROBINS



When it's more than a bad cold



your patient can feel better while she's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

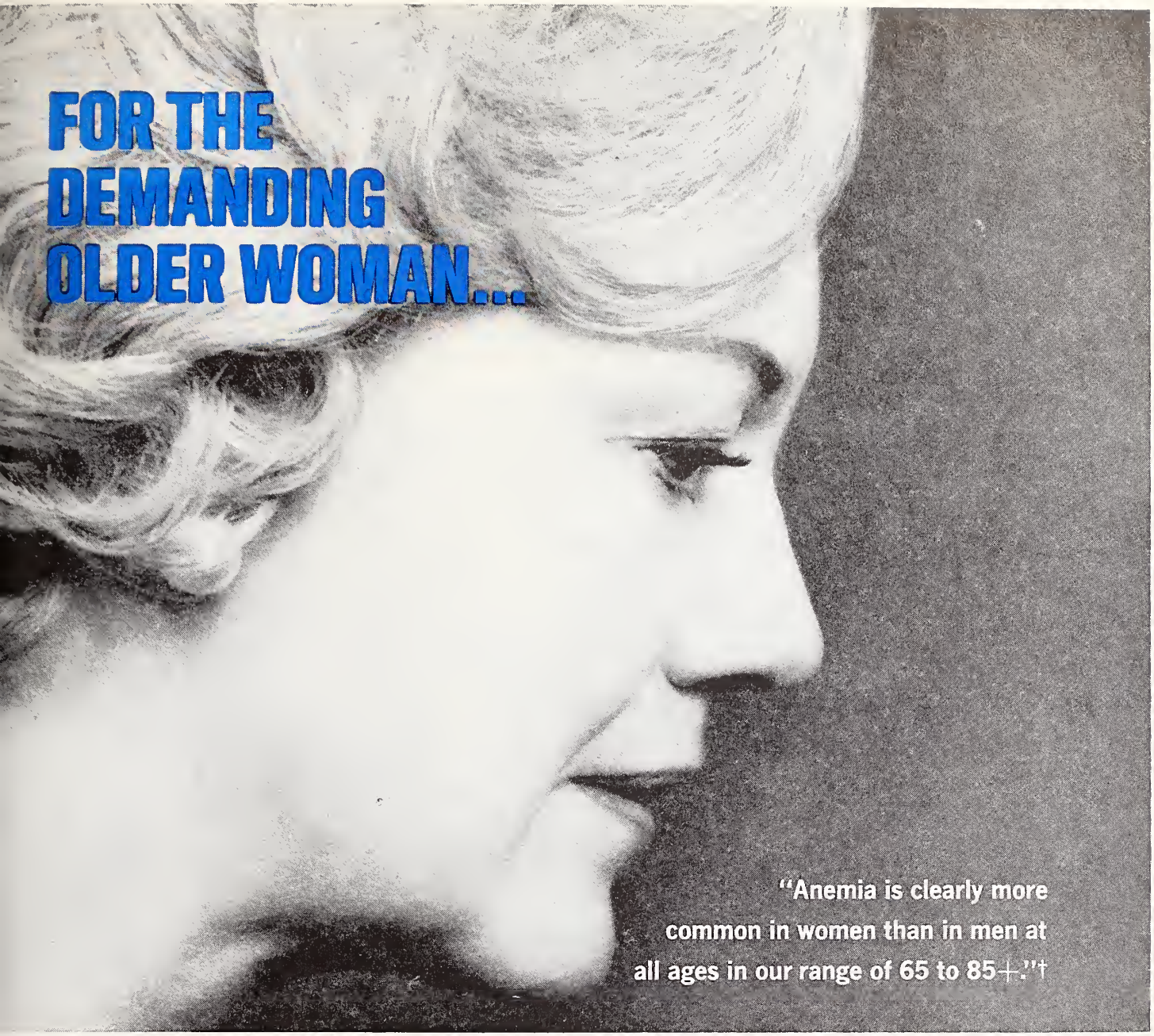
Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

349-8



sustained-release

Mol-Iron® Panhemic Chronosule®*

capsules

To help overcome the inadequacies of poor absorption and insipid diet common in the geriatric patient—a superior, sustained-release hematinic combined with key vitamins.

Each Mol-Iron Panhemic Chronosule capsule contains: Ferrous sulfate, 390 mg. (78 mg. elemental iron) and Molybdenum sesquioxide, 6 mg. in sustained-release form; Vitamin B_{12}, 25 mcg.; Vitamin B_1, 6 mg.; Vitamin B_2, 6 mg.; Vitamin B_6, 5 mg.; Niacinamide, 30 mg.; Vitamin C, 150 mg. Supplied: bottles of 30.

*brand of sustained-release capsule

†Parsons, P.L., Withey, J.L., and Kilpatrick, G.S : Practitioner 195:656, (Nov) 1965.

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BETTER TOLERATED—HELPS ASSURE MORE PREDICTABLE ABSORPTION AND OPTIMAL HEMOGLOBIN RESPONSE

SUPERIOR TO CONVENTIONAL FERROUS SULFATE

In 'Toler-ability'

Slowly-liberated, molybdenized ferrous sulfate virtually eliminates gastrointestinal side effects.

So well tolerated it can be taken on an empty stomach.

In 'Absorb-ability'

Gradual release of better tolerated, molybdenized ferrous sulfate helps assure more predictable absorption.

In 'Dose-ability'

Just a single Mol-Iron Panhemic Chronosule capsule daily generally corrects mild to moderate hematologic and nutritional deficiencies.

She isn't burdened by her hypertension or her therapy...



Butiserpazide® lowers blood pressure so smoothly that patients are often untroubled by either the disease...or treatment

BUTISERPAZIDE provides not only the classic thiazide/reserpine formula; it supplements it with the mildly sedative effect of BUTISOL (butabarbital).

Clinical comparisons have shown that many patients respond to this treatment with (1) smooth, uniform lowering of blood pressure[1]...at times *below* the levels attained with previous therapy[2]; (2) "striking" improvement in such symptoms as headache, nervousness, palpitation and dizziness[2]; plus (3) "...lowered incidence of drug side effects."[2]

And BUTISERPAZIDE offers an added advantage: the usual dosage is just 1 tablet once or twice daily. It is available in two strengths for dosage flexibility.

Are there any hypertensives in *your* practice who might find life a little pleasanter on BUTISERPAZIDE?

Contraindications: Sensitivity to any component, porphyria, peptic ulcer, ulcerative colitis, mental depression, renal impairment or shutdown. **Warnings:** Consider the possibility of sensitivity reactions in patients with history of allergy or bronchial asthma. Coated potassium tablets, sometimes administered in conjunction with antihypertensive therapy, may be associated with small bowel lesions, which have led to obstruction, hemorrhage and perforation. Surgery has frequently been required and deaths have occurred. Such tablets should be used only when indicated and when adequate dietary supplementation is not practical. They should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occur. *Use in Pregnancy:* Exercise caution, since thiazides cross the placental barrier and may cause fetal or neonatal hyperbilirubinemia, thrombocytopenia or altered carbohydrate metabolism; adverse reactions seen in the adult may occur in the newborn. Use reserpine in women of child-bearing age only when essential to patient welfare. Increased respiratory secretions, nasal congestion, cyanosis, and anorexia may occur in infants born to reserpine-treated mothers. **Precautions:** *Butisol* (butabarbital)—Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression. *Hydrochlorothiazide*—May induce electrolyte imbalance; when used with digitalis or one of its glycosides and in patients with severe hepatic insufficiency, cardiac arrhythmias or symptoms of impending hepatic coma may occur. Discontinue and institute appropriate countermeasures if prolonged use produces hypokalemia or (likely with sodium restriction) hyponatremia and hypochloremic alkalosis. (Ammonium chloride, used to reverse hypochloremic alkalosis, is contraindicated in hepatic disease.) May produce elevated serum uric acid levels (and, infrequently, gout) or reduce glucose tolerance, altering insulin requirements in diabetics. *Reserpine*—Observe for signs or symptoms of peptic ulcer or ulcerative colitis. Discontinue at first sign of mental depression; keep in mind possibility of suicide. Exercise extreme caution in history of mental depression. May produce cardiac arrhythmias when used with digitalis and quinidine, or may precipitate biliary colic in patients with gallstones. Discontinue 1 to 2 weeks before surgery; inform the anesthetist in event of emergency surgery. Exercise caution in history of epilepsy. Discontinue 1 to 2 weeks before ECT. *General*—Exercise caution in coronary artery disease. **Adverse Reactions:** Dizziness, drowsiness, weakness, nasal congestion, leg cramps, nausea, palpitations, superficial skin bruises, palmar erythema, headache, dehydration, skin rash, "hangover," systemic disturbances, diarrhea, itching, vomiting, paresthesia, photosensitivity, pancreatitis, jaundice, xanthopsia, purpura, thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia, anorexia, gastric irritation, abdominal cramping, constipation, glycosuria, vertigo, cutaneous vasculitis, orthostatic hypotension (potentiated by alcohol, barbiturates, or narcotics), increased salivation and gastric secretion, increased intestinal motility, loose stools, angina-like syndrome, arrhythmias, bradycardia, flushing, hypotension, nervousness, paradoxical anxiety, rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, optic atrophy), dryness of mouth, syncope, epistaxis, weight gain, and impotence or decreased libido. **Usual Adult Dosage:** BUTISERPAZIDE®-25 or BUTISERPAZIDE®-50: 1 tablet daily or b.i.d. When used with other antihypertensive agents reduce dosage of both drugs about 50% and observe carefully for changes in blood pressure. *Before prescribing or administering, see package insert.* **References:** 1. Johnson, H. J., Jr.: Penna. M. J. **67**:35, 1964. 2. Coodley, E. L.: Curr. Ther. Res. **4**:460, 1962.

Butiserpazide®-25

PRESTABS®* Tablets

BUTISOL® (butabarbital) 30 mg.†; Hydrochlorothiazide 25 mg.; Reserpine 0.1 mg.

Butiserpazide®-50

PRESTABS®* Tablets

BUTISOL® (butabarbital) 30 mg.†; Hydrochlorothiazide 50 mg.; Reserpine 0.1 mg.

†**Warning:** May be habit forming.

*15 mg. of **Butisol** (butabarbital), plus the other ingredients, in outer layer; 15 mg. of **Butisol** (butabarbital) in a specially coated core for delayed release, to approximately equalize duration of action for all components.

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New

Therapeutic breakthrough in non-narcotic control of the pain of

Tegretol®
carbamazepine

trigeminal neuralgia

Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the drug should be discontinued.
2. Liver function tests must be performed at regular intervals during treatment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated with Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytosis, eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary frequency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urine, impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, erythema multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexia, dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular effects are drug-related is not known. However, some of these complications have resulted in fatalities.) The necessity for discontinuing the drug should be dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with meals, if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the dose should be increased in one-half tablet (100 mg.) increments every 12 hours until freedom from pain is achieved. To relieve pain, between 200 mg. and 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should be made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-A
For complete details, please see Prescribing Information.

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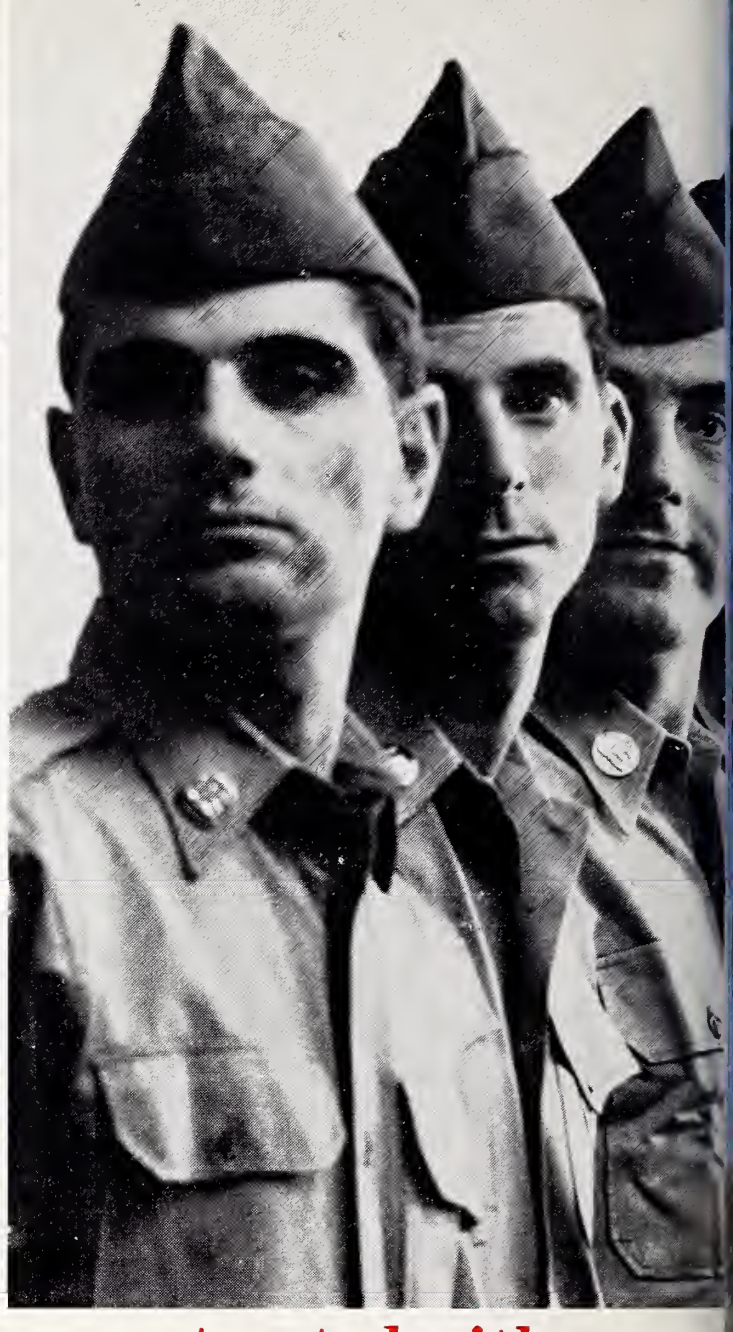
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uncommon relief of uncommon pain





Picture of torticollis



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Paraflex® (chlorzoxazone)* 250 mg.
Tylenol® (acetaminophen) 300 mg.

Parafon Forte helps to relieve pain, restore mobility...stop pain-spasm feedback

Here is why. PARAFON FORTE provides:

a nonsalicylate analgesic equal to aspirin for the relief of pain,[1,2] yet unlikely to produce the irritation to the gastric mucosa so often associated with salicylate therapy[3]

and a skeletal muscle relaxant shown to have up to a 6-hour span of action[4]...to retain effectiveness even on continued administration[4]...but not likely to have the central effects of tranquilizing compounds.[5]

Prescribe PARAFON FORTE for effective spasmolysis and analgesia in sprains, strains, myalgias, low back pain, bursitis and other musculoskeletal disorders. Your patients will appreciate the restored comfort and freedom of movement it usually provides.

Contraindications: Sensitivity to either component. ***Precaution*** Exercise caution in patients with known allergies or history o drug allergies. If a sensitivity reaction or signs or symptoms sug gestive of liver dysfunction are observed, the drug should b stopped. ***Adverse Reactions:*** Occasionally, drowsiness, dizzines lightheadedness, malaise, overstimulation or gastrointestina disturbances may be noted; rarely, allergic-type skin rashe petechiae, ecchymoses, angioneurotic edema or anaphylact reactions. In rare instances, *Paraflex* (chlorzoxazone) may pos sibly have been associated with gastrointestinal bleeding. Whil *Paraflex* (chlorzoxazone) and chlorzoxazone-containing proc ucts have been suspected as being the cause of hepatic toxicit in approximately eighteen patients, it was not possible to stat that the dysfunction was or was not drug induced. ***Usual Adu Dosage:*** Two tablets q.i.d. ***Supplied:*** Scored, light green tablet imprinted "McNEIL"—bottles of 100.

References: 1. Batterman, R. C., and Grossman, A. J.: Fed. Proc. *14*:31 1955. 2. Goodman, L. S., and Gilman, A., ed.: The Pharmacological Basis Therapeutics, ed. 3, New York, The Macmillan Company, 1965, p. 331. 3. Rot J. L. A., *et al.*: Gastroenterology *44*:146, 1963. 4. Berman, H. H., *et al.*: Di Nerv. Syst. *25*:430, 1964. 5. Frien D. G.: Clin. Pharmacol. Ther. *5*:87 1964.

*U.S PATENT NO. 2,895,8

McNEIL

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Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient sodium excretion is greatly enhanced. Yet potassium loss is lo

The therapeutic action is smooth, and persists for a full 24 hour With Enduron you can prescribe convenient once-a-day dosag without skimping your patients on day-long thiazide effectivenes

Of course, as with all thiazides, supplemental dietary potassiu should also be considered.

Use Enduron as a basic therapy in patients with mild to mo erate hypertension. A single 5-mg. tablet each day is ample most cases.

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MILD TO MODERATE TO SEVE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

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Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

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METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

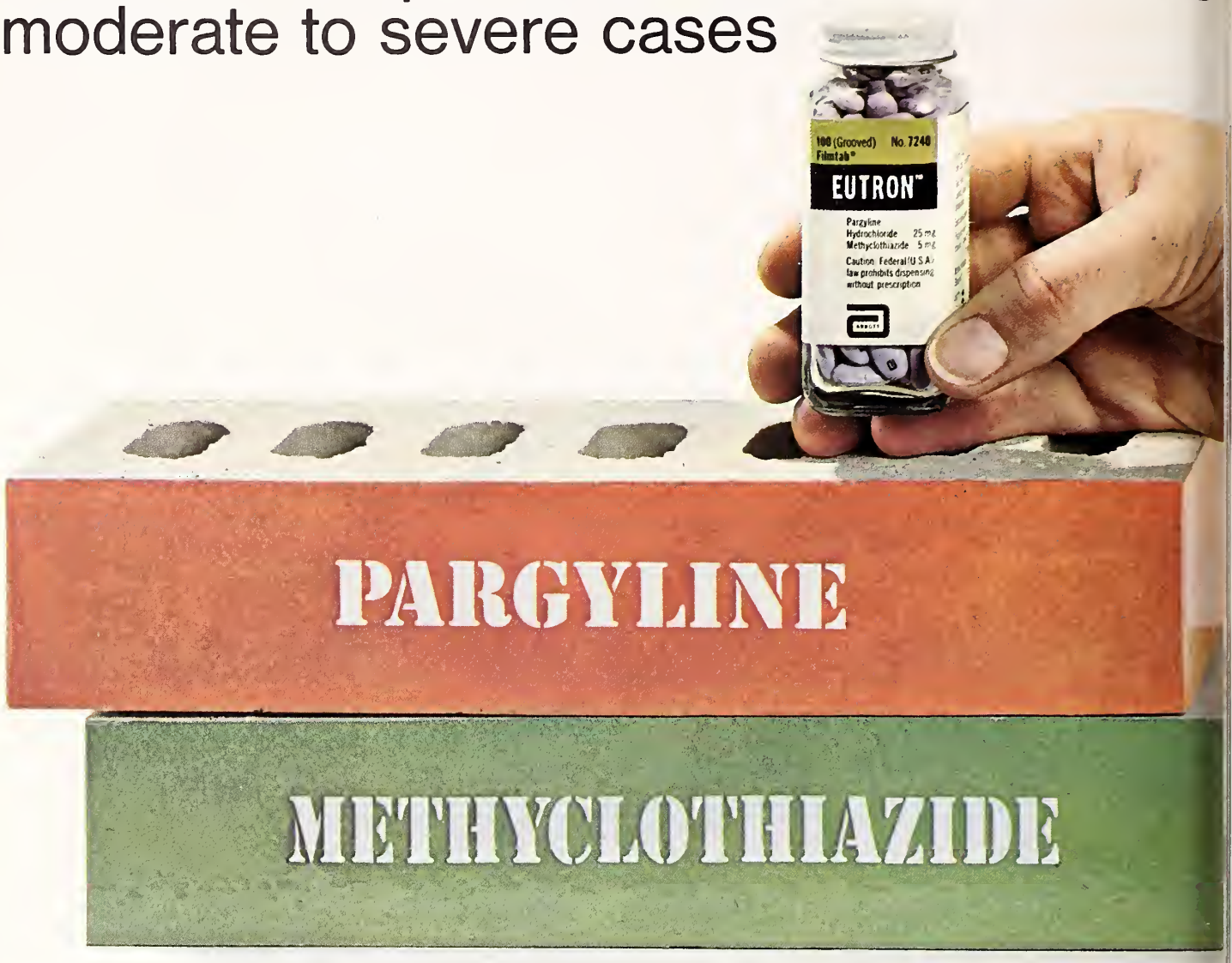
MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

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Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains Methyclothiazide 5 mg. with Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

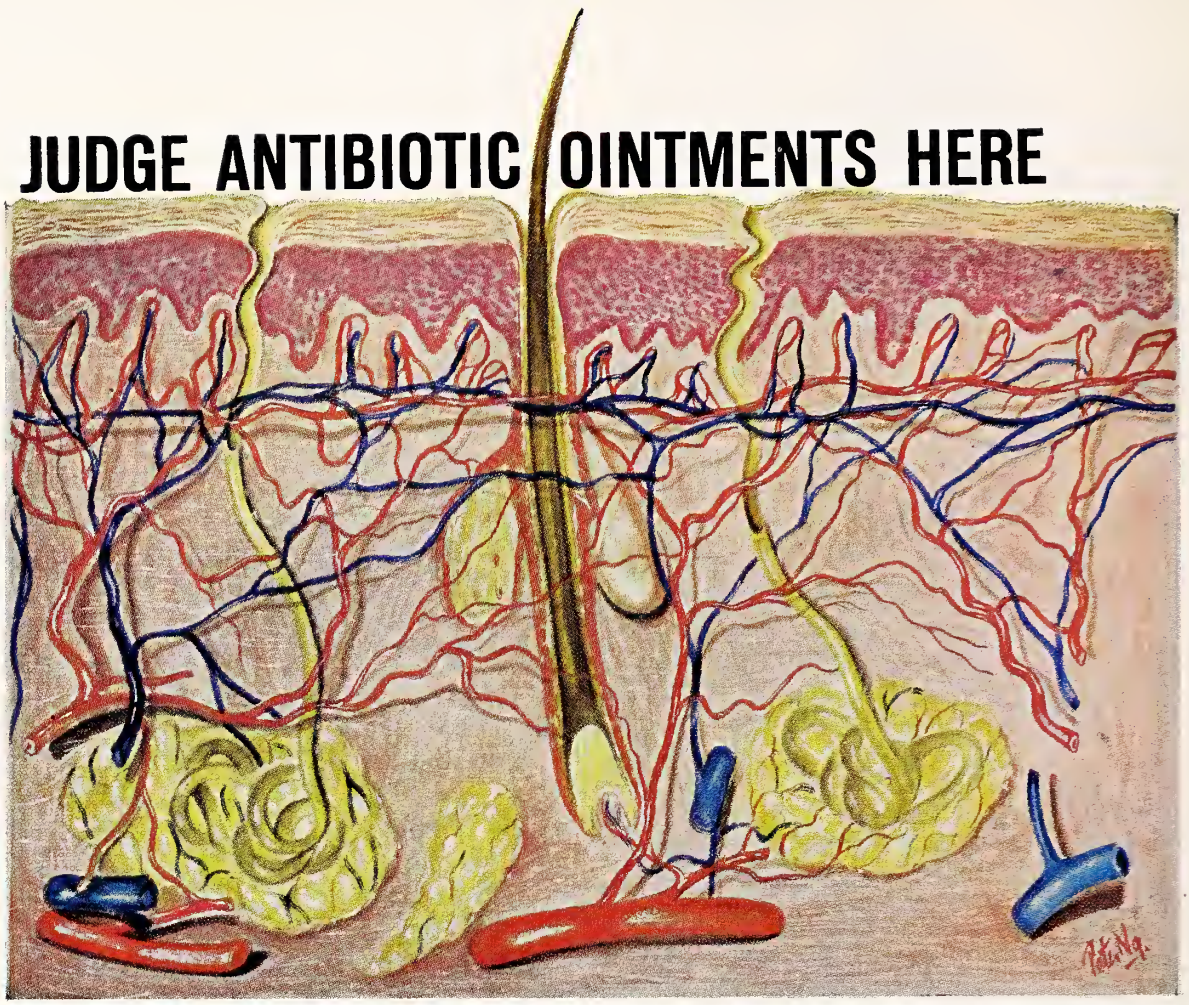
Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

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ALL INFORMATION KEPT CONFIDENTIAL

Date_____

Name_____ M.D. Sex_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Net Income From Your Practice $_____ For 1966 $_____ For 1965 $_____ For 1964

Do You Have an Ownership in Any Unincorporated Trade or Business?_____

NOTE: If your practice is a partnership, please attach separate information giving the same data as above for each partner.

Employees, If Any: Name	Sex	Date of Birth	Date Employed	Salary	Full or Part Time

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PROCUREMENT AND ASSIGNMENT COMMITTEE: Joseph M. Greer, M.D., Chairman (Phoenix); Donald K. Buffmire, M.D. (Phoenix); Louis Hirsch, M.D. (Tucson); Elvie B. Jolley, M.D. (Bisbee); George H. Mertz, M.D. (Phoenix); Jack 1. Mowrey, M.D. (McNary); James T. O'Neil, M.D. (Casa Grande).

PROFESSIONAL COMMITTEE: William G. Payne, M.D., Chairman (Tempe); Robert J. Antos, M.D. (Phoenix); Earl J. Baker, M.D. (Phoenix); Robert I. Cutts, M.D. (Tucson); Richard L. Dexter, M.D. (Tucson); Jack D. Fatheree, M.D. (Phoenix); Robert S. Ganelin, M.D. (Phoenix); William B. Helme, M.D. (Phoenix); Harold W. Kohl, Jr., M.D. (Tucson); W. Shaw McDaniel, M.D. (Phoenix); Dermont W. Melick, M.D. (Tucson); Hermann S. Rhu, Jr., M.D. (Tucson); Donald F. Schaller, M.D., (Phoenix); Albert G. Wagner, M.D. (Phoenix); MacDonald Wood, M.D. (Phoenix).

MEMBERS ARE URGED TO BRING MATTERS OF INTEREST AND CONCERN TO THE CHAIRMEN OF THE APPROPRIATE COMMITTEE OR TO THE ATTENTION OF ANY MEMBER OF THE BOARD OF DIRECTORS.

AN INVOLVED MEMBERSHIP IS THE BASIS FOR AN EFFECTIVE ASSOCIATION.

PUBLIC RELATIONS COMMITTEE: John F. Kahle, M.D., Chairman (Flagstaff); Walter R. Eicher, M.D. (Chandler); Richard O. Flynn, M.D. (Tempe); C. Herbert Fredell, M.D. (Flagstaff); Don V. Langston, M.D. (Phoenix); William H. Lyle, M.D. (Yuma); William W. McKinley, Jr., M.D. (Bisbee); Jack I. Mowrey, M.D. (McNary); Harry L. Reger, Jr., M.D. (Phoenix); Roland F. Schoen, M.D. (Casa Grande); William C. Scott, M.D. (Tucson); Philip D. Volk, M.D. (Tucson).

PUBLISHING COMMITTEE: Roland F. Schoen, M.D., Chairman (Casa Grande); R. Lee Foster, M.D. (Phoenix); John R. Green, M.D. (Phoenix); Felix F. Jabczenski, M.D. (Tucson); Kenneth E. Johnson, M.D. (Phoenix); Robert F. Lorenzen, M.D. (Phoenix); William B. McGrath, M.D. (Phoenix); Preston J. Taylor, M.D. (Tucson).

SCIENTIFIC ASSEMBLY COMMITTEE: Edward Sattenspiel, M.D., Chairman (Phoenix); Clifton J. Alexander, M.D. (Tucson); William E. Bishop, M.D. (Globe); Daniel Bright, M.D. (Cottonwood); John F. Currin, M.D. (Scottsdale); Milton S. Dworin, M.D. (Tucson); T. Richard Gregory, M.D. (Phoenix); Raymond Grossman, M.D. (Douglas); Rockwell E. Jackson, M.D. (Tucson); George B. Kent, Jr., M.D. (Phoenix); Fred H. Landeen, M.D. (Tucson); Philip Levy, M.D. (Phoenix); Laurance M. Linkner, M.D. (Phoenix); William F. Middleton, M.D. (Phoenix); Arthur R. Nelson, M.D. (Phoenix); Paul J. Nichols, M.D. (Phoenix); Melvin W. Phillips, M.D. (Prescott); Wilfred M. Potter, M.D. (Scottsdale); Blair W. Saylor, M.D. (Tucson); John S. Welsh, M.D. (Tucson); Reginald J. M. Zeluff, M.D. (Phoenix).

COUNTY MEDICAL SOCIETY OFFICERS 1968-69

APACHE: Arnold H. Dysterheft, M.D., President, McNary Hospital, McNary; Paddy R. Garver, M.D., Secretary, P.O. Box 919, Show Low.

COCHISE: Robert E. Montgomery, M.D., President 1101 San Antonio Dr., Douglas; James M. Gilbert, M.D., Secretary, Copper Queen Hospital, Bisbee.

COCONINO: Gerald T. McMahon, M.D., President, 1355 North Beaver, Flagstaff; David D. Smith, M.D., Secretary, 715 North Beaver, Flagstaff.

GILA: Jesse E. Jacobs, M.D., President, Box Z, Miami; T. E. Matheson, M.D., Secretary, Miami-Inspiration Clinic, Miami.

GRAHAM: Frederick W. Knight, M.D., President, 618 Central Avenue, Safford; Jack L. Bennett, M.D., Secretary, 618 Central Avenue, Safford.

GREENLEE: Robert V. Horan, M.D., President, Morenci Hospital, Morenei; James W. Gilbert, M.D., Secretary, P. O. Box 1537, Clifton.

MARICOPA: Arthur R. Nelson, M.D., President, 926 E. McDowell Rd., Phoenix; Donald F. Schaller, M.D., Seeretary, 55 W. Catlina Drive, Phoenix.
(Society Address: 2025 North Central Avenue, Phoenix)

MOHAVE: George M. Clarke, M.D., President, 412 East Oak Street, Kingman; John J. Standifer, M.D., Secretary, 412 East Oak Street, Kingman.

NAVAJO: Leo L. Lewis, M.D., President, P. O. Box AT, Winslow; George G. Bertino, Jr., M.D., Seeretary, 1500 Williamson Avenue, Winslow.

PIMA: John A. Wilson, M.D., President, 1601 N. Tucson Boulevard, Tucson; Seymour I. Shapiro, M.D., Secretary, Bldg. 24, Med. Square, 1601 N. Tucson Blvd., Tucson.
(Society Address: 2555 East Adams Street, Tucson)

PINAL: William J. Clemans III, M.D., President, 1616 Main Street, Florence; Robert L. Hyde, M.D., Secretary, 1616 Main Street, Florence.

SANTA CRUZ: Stephen A. Letourneaux, M.D., President, 711 Morley Ave., Nogales; Charles S. Smith, M.D., Secretary, Gebler Building, Nogales.

YAVAPAI: Edward L. Ritter, M.D., President, 533 West Gurley Street, Prescott; William R. Shepard, M.D., Secretary, 1003 Division Street, Prescott.

YUMA: John F. Stanley, M.D., President, 201 First Avenue, Yuma; Dale F. Webb, M.D., Secretary, Avenue A and 24th Street, Yuma.

WOMAN'S AUXILIARY TO THE ARIZONA MEDICAL ASSOCIATION — 1968-69

President Mrs. Lewis S. Winter (Jean)
1714 E. Rose Lane, Phoenix 85016

President-Elect Mrs. Robert J. Oliver (Nicki)
910 N. Wilmot Road, Tucson

1st Vice President Mrs. Robert P. Mason (Doris)
330 W. Maryland Apt. 107, Phoenix 85013

2nd Vice President Mrs. Evaristo Martinez (Frances)
1172 Country Club Drive, Prescott 86301

Treasurer Mrs. William O. Minturn (Shirley)
6034 N. 38th Place, Scottsdale 85018

Recording Secretary Mrs. Dale F. Webb (Lynn)
2200 E. 25th Place, Yuma 85364

Corresponding Secretary Mrs. Rex O. Vaubel (Eileen)
117 W. Glenn Dr., Phoenix 85021

Director (2 Years) Mrs. Carl Shrader (Ginny)
527 Bertrand, Flagstaff 86001

Director (1 Year) Mrs. John E. Oakley (Helen)
57 A Country Club Dr., Prescott 86301

Director (1 Year) Mrs. Elvie B. Jolley (Mila)
301 Cole Avenue, Warren 85642

CHAIRMEN OF STANDING COMMITTEES 1968-69

AMA-ERF: Mrs. Albert G. Wagner (Helen)
3216 E. Meadowbrook (956-3674), Phoenix 85018

BY-LAWS: Mrs. Charles E. Matheus (Marilyn)
2148 E. 25th St., Yuma 85364

CHAPLAIN: Mrs. J. B. Tucker (Laverne)
700 East 10th St., Casa Grande 85222

COMMUNITY HEALTH: Mrs. Harry D. Bryan
Yuma 85364

CONVENTION Mrs. Howard Kimball (Ella)
414 W. Northview Avenue, Phoenix 85021

FINANCE: Mrs. James L. Parsons
5251 E. Hawthorne, Tucson 85711

GEMS: Mrs. James Alway
1677 E. Maryland, Phoenix 85016

HEALTH CAREERS: Mrs. William Scott (Jean)
340 S. Country Club Rd. (326-5354), Tucson 85716

HAMER EDUCATION LOAN FUND:
Mrs. Alvin L. Swenson (Viki)
5250 Bartlett Circle, Phoenix 85016

HISTORIAN: Mrs. Melvin Phillips (Jean)
1001 Norris Road, Prescott 85018

INTERNATIONAL HEALTH: Mrs. Rexford Peterson (Dell)
6130 N. 52nd Plaee (945-9250), Paradise Valley 85251

LEGISLATION: Mrs. George S. Enfield (Ro)
1226 E. Cambridge Ave. (265-2507), Phoenix 85016

MENTAL HEALTH Mrs. Isadore Sklar (Marion)
1513 E. San Miguel, Phoenix 85014

NOMINATING: Mrs. Elvie B. Jolley (Mila)
301 Cole Ave. Warren 85642

PARLIAMENTARIAN: Mrs. Clare W. Johnson (Mary Anne)
318 W. Lawrenee Rd. (266-1410), Phoenix 85013

PUBLICATION: Mrs. Hubert R. Estes (Mickie)
9035 E. Woodland Road (298-1289), Tucson 85715

SAFETY-DISASTER PREPAREDNESS:
Mrs. Charles I. Fisher (Peggy)
352 W Berridge Lane, Phoenix 85013

WA-SAMA Mrs. Bryant I. Pickering (Jean)
4801 E. Sparkling Lane, Paradise Valley 85251

COUNTY PRESIDENTS 1968-69

MARICOPA Mrs. George L. Hoffmann (Julie)
900 W. Mountain View Dr., Mesa 85201

COCONINO Mrs. Darius Benham (Esther)
527 Bertrand, Flagstaff 86001

YUMA Mrs. Paul Slosser (Betty)
701 E. 8th Avenue, Yuma 85364

PIMA Mrs. Richard F. Dahlen
3210 E. Via Palos Verdes, Tucson 85716

YAVAPAI Mrs. John Oakley (Helen)
57 A. Country Club, Prescott 86301

GILA Mrs. Thomas Jarvis (Barbara)
1266 Skyline Drive, Globe 85501

ArMA Reports

BOARD OF DIRECTORS

Meeting of the Board of Directors of The Arizona Medical Association, Inc., held Sunday, July 14, 1968, in the Convention Center of the Safari Hotel, Scottsdale, Arizona, convened at 10:05 A.M., Richard O. Flynn, M.D., President-Elect and Acting Chairman, presiding.

ROLL CALL

PRESENT: Drs. Beckwith, Harry S.; Brooks, Jack E.; Cloud, Daniel T.; Czerny, Everett W.; Dew, Philip E., Treasurer; Dudley, Jr., Arthur V., President; Dysterheft, Arnold H., Past President; Flynn, Richard O., President-Elect; Heileman, John P., Secretary; Henderson, Charles E.; Jarrett, Paul B.; Moody, Deward G.; Price, Robert A.; Rhu, Jr., Hermann S.; Sattenspiel, Edward; Schoen, Roland F.; Scott, William C.; Shapiro, Seymour I.; Standifer, John J.; Steen, William B.

Counsel: Mr. Jacobson.

Staff: Messrs. Carpenter, Robert, Executive Secretary — ArMA; Robinson, Bruce E., Assistant Executive Secretary — ArMA; Boykin, Paul R., Executive Secretary — BOMEX.

Guests: Dr. Webb, Dale F., Secretary, representing the President of the Yuma County Medical Society.

EXCUSED: Drs. Finke, Howard W.; Grobe, James L.; Landeen, Fred H., Vice President; Young, Woodson C.

WELCOME

A quorum being present, Dr. Flynn called the meeting to order extending a cordial welcome to the guest in attendance.

MINUTES

Approved minute of the meeting of the Board of Directors of this Association held May 26, 1968.

ArMPAC BOARD OF DIRECTORS

In the absence of John F. Kahle, M.D., Chairman of the Board of Directors of ArMPAC, a written report was presented and read indicating that the 1968 ArMPAC membership is now over 650 members, which is by far the largest it has ever been. It is the hope a goal of 700 will be reached. Closing date for filing for the Primary Election is July 11th. Shortly thereafter consideration will be given as to support of candidates. RECEIVED.

Approved the recommended membership composite of the Board of Directors of ArMPAC for the year 1968-69 or until their successors are appointed: John F. Kahle, M.D., Chairman (Flagstaff); Walter Brazie, M.D. (Kingman); Doyle Hansen, D.D.S. (Holbrook); Paul A. Hayes, D.D.S. (Phoenix); Ray P. Inscore, M.D. (Prescott); Mrs. Clare W. Johnson (Phoenix); Mrs. Elvie B. Jolley (Bisbee); Paul W. Kliewer, M.D. (Wickenburg); Don V. Langston, M.D. (Phoenix); William G. Payne, M.D. (Tempe); Eugene A. Savoie, D.D.S. (Tucson); William B. Steen, M.D. (Tucson); Sherman W. Thorpe, M.D. (Mesa); and Mrs. Richard P. Timmons (Phoenix). Richard O. Flynn, M.D., President-Elect (Tempe), because of his office, requested and was granted permission to withdraw his name for consideration on the ArMPAC Board. Three additional vacancies exist, appointments to which will be recommended at a later date.

HOUSE OF DELEGATES

Resolution No. 6 — Building Program — Assessment

For the edification of the members of the Board of Directors, Dr. Dudley reviewed in detail developments regarding the Central Office Headquarters Building Program, both before and following the joint meeting of the Executive Committees of ArMA and the component Maricopa County Medical Society held June 29, 1968. A transcript of the latter meeting is included in the agenda folder furnished each Board member. Considerable discussion ensued.

It was determined: (1) that the release of the mailing of the assessment notice scheduled for July 15, 1968, be deferred until after the next meeting of the Board of Directors scheduled to be held September 8, 1968; (2) that a meeting will be called by the component Maricopa County Medical Society to be held September 5, 1968, for the purpose of ventilating the entire Building Program; and (3) that an Ad Hoc Building Committee be appointed to include members of the Maricopa Society. This new committee will be comprised of the membership of the Executive Committee of ArMA, Arthur R. Nelson, M.D., President of Maricopa County Medical Society, Robert A. Price, M.D. and Woodson C. Young, M.D., members of this Board of Directors. A meeting will be called shortly. It was further agreed that a "flier" will be mailed to the membership of Maricopa Society setting forth these decisions and assuring it that no final decision will be made until after the September 5, 1968 meeting of Maricopa. Dr. Flynn agreed to contact Dr. Nelson to ascertain whether or not it would be agreeable to invite members other than those from Maricopa to attend the September meeting for further enlightenment.

Resolution No. 7—Building Program—Land—Architect

It was pointed out that the report of the Appraiser, Mr. Frank Kelly, is included in the agenda folder. It was pointed out that the prime property recommended, located at 4th and Clarendon, Phoenix, initially offered at a price of $2.43 per square foot ($180,000.00) had been re-appraised and is now offered at $3.25 per square foot. No site, as yet, has been determined upon. The newly formed Building Committee will review all of the sites currently proposed, any additional ones offered, consider the merits and/or demerits of including para-medical groups and Maricopa Society as possible tenants (taking into account its possible effect upon the non-profit tax exemption status of the Association in the instance of becoming a landlord) and further look into condominium type construction.

No architect or firm of architects, as yet, has been selected. Approximately six have submitted proposals. It was requested that the firm of architects headed by Donald D. Schwenn be included. Likewise, no action will be taken in this regard until after the next Board meeting. Discussion ensued regarding site locations and whether Scottsdale had been considered. It was stated that basically properties in close proximity to the Freeway and located near the State Capitol were sought, reviewed and evaluated.

Resolution No. 8 — Re-dedication of B. & L. Funds

This Resolution provided for the re-dedication of Benevolent and Loan Funds to the ArMA Building Fund. The Valley National Bank delivered the following close-

out checks representing Trust Account No. 120-03068 totaling $44,112.56 (interest $6,471.18 and principal $37,-641.38), and Trust Account No. 170-04714 totaling $11,625.35 (interest $1,147.45 and principal $10,477.90). These checks have been deposited in the newly created Building Fund.

It was regularly moved and unanimously carried that the sum of $7,618.63 be transferred to and deposited in the "Benevolence" account; that $3,000.00 be transferred to and deposited in the "Scholarship" fund, this sum having been previously borrowed from this account as a guarantee deposit in the medical student loan account (VNB Trust No. 170-04714); and that $1,277.00, representing donations received, be transferred to and deposited in the Arizona Medical Association Foundation account being established.

BOARD OF DIRECTORS

Board of Medical Examiners

Governor Jack Williams appoints Francis M. Findlay, M.D. (San Manuel) a member of the Board of Medical Examiners of the State of Arizona (Chapter 13, Arizona Revised Statutes, as amended), effective July 1, 1968, expiring July 1, 1973. RECEIVED.

Arizona Health Planning Authority

Governor Jack Williams appoints: Paul B. Jarrett, M.D. and James M. Kilgore, Jr., M.D., both of Phoenix, members of the Arizona Health Planning Authority (Chapter 162, Laws of 1968). RECEIVED.

Hospital Advisory Council of Arizona

George A. Spendlove, M.D., Commissioner — Arizona State Department of Health, appoints: Clarence E. Yount, Jr., M.D. (Prescott), a member of the Hospital Advisory Council of Arizona for the term expiring December 31, 1968. RECEIVED.

Governmental Services Committee

Clifton J. Alexander, M.D. (Tucson), Albert J. Ochsner, II, M.D. (Yuma) and Keith R. Treptow, M.D. (Tucson) accept appointment to membership on this Committee. RECEIVED.

Professional Committee

Robert I. Cutts, M.D. (Tucson) accepts appointment to membership on this Committee. RECEIVED.

Scientific Assembly Committee

Edward Sattenspiel, M.D. (Phoenix 1967-70) accepts the Chairmanship of this Committee for the term 1968-69. RECEIVED.

Arizona Medical Association Foundation

Edward Jacobson, Counsel, reported that there has been incorporated a non-profit corporation called the Arizona Medical Association Foundation. Because the name is very close to the name of this Association, deliberately, we need to file with the Corporation Commission, a resolution to be adopted by this Board of Directors permitting the use of the name.

It was regularly moved and unanimously carried that the following resolution, presented and read, be adopted:

> RESOLVED, that The Arizona Medical Association, Inc. does hereby consent to and authorize the use of the corporate name: "Arizona Medical Association Foundation: for a non-profit corporation organized under the Laws of the State of Arizona."

MEETING ADJOURNED TEMPORARILY FOR THE PURPOSE OF CONDUCTING BUSINESS OF THE ARIZONA MEDICAL ASSOCIATION FOUNDATION.

* * * * *

MEETING RECONVENED, ALL MEMBERS RESPONDING TO THE INITIAL ROLL CALL PRESENT, RICHARD O. FLYNN, M.D., PRESIDENT-ELECT AND ACTING CHAIRMAN, PRESIDING.

BENEVOLENT AND LOAN FUND COMMITTEE

Timothy C. Kennedy (Tucson), Graduate of the University of Arizona, attending Columbia University College of Physicians and Surgeons, awarded a Scholarship of $500.00. RECEIVED.

EXECUTIVE COMMITTEE

ArMA Membership Classification Changes

MARICOPA

Carmine A. Cilella, M.D. (Tempe) — Granted Service (¼ Dues) account Full-Time Employment — Arizona State Tuberculosis Sanatorium, Tempe, effective 5/27/68.

James E. Lett, M.D. (Phoenix) — Recommended for Service (¼ Dues) account Full-Time Employment Medical Education Director, Good Samaritan Hospital, Phoenix, effective 6/25/68. Determined to defer action and communicate with Maricopa County Medical Society for clarification as the employment described does not qualify Dr. Lett as a governmental employee.

Niels H. Poulsen, M.D. (Phoenix — now Ethiopia) Service, granted Affiliate (dues exempt) account Appointment as Chief of the Public Health Division of the United States Aid Program to Ethiopia, effective 3/19/68.

J. Kendall Wallis, M.D. (Scottsdale) — Granted Affiliate (dues exempt) account Retired, holding M.D. Degree and residing in Arizona, effective 7/1/68.

PIMA

Thomas E. A. Von Dedenroth, M.D. (Tucson) — Active, granted Associate (dues exempt) account Residency Training, effective 7/1/68.

Robert B. Johnson, M.D. (Deceased 3/29/68) formerly holding Active membership, family requests dues refund ($105.00 paid 2/13/68). Determined not eligible account Death After Delinquency Date 2/15/68.

William G. Ure, M.D. (Deceased 2/15/68) formerly a Service member, family requests dues refund ($26.25 paid 2/9/68). Determined not eligible because of membership classification, only Active membership classification eligible.

It was regularly moved and unanimously carried that because of family hardship in each case and the fact that Pima County Medical Society has refunded its dues collected for similar reason, and further due to the fact that the ArMA Bylaws do not provide for dues refunds under the circumstances in these two cases, the sums of $105.00 and $26.25 are authorized paid to the family of Robert B. Johnson, M.D. (Deceased) and the family of William G. Ure, M.D. (Deceased) respectively, payable out of the "Benevolence" fund of this Association.

It was regularly moved and unanimously carried that the Articles of Incorporation and Bylaws Committee under the Chairmanship of Charles E. Henderson, M.D., be instructed to look into a further change in the Bylaws to make the benefit under "death" correspond with those provided for "Armed Forces" service and "Approved Residency or Other Post-Graduate Training Program,"

it being understood that such refunds shall be by request only as currently provided.

It was regularly moved and unanimously carried that there be referred to the Artieles of Incorporation and Bylaws Committee for review and definition under Service Members "full-time medical employees" of non-governmental institutions.

Financial Report

Accepted the report of the Treasurer, Dr. Dew, for the month of May, 1968, setting forth total "INCOME" received amounting to $12,681.50 (total income received to date $187,904.54), reflecting an "under-budget" of $16,470.46 (1968 Budget $204,375.00), and "EXPENDITURES" of $39,577.35 (total expenditures to date $105,-808.34), reflecting an "under-budget" of $97,630.66 (1968 Budget, as amended, $203,439.00).

Accepted the report of the Treasurer, Dr. Dew, for the month of June, 1968 setting forth total "INCOME" received amounting to $3,269.25 (total income received to date $191,173.79), reflecting an "under-budget" of $13,-201.21 (1968 Budget $204,375.00), and "EXPENDITURES" of $14,151.93 (total expenditures to date ($119,-960.27), reflecting an "under-budget" of $83,478.73 (1968 Budget, as amended, $203,439.00).

Authorized the following additional appropriation out of contingency ($936.00):

521 Audit — $250.00

History and Obituaries Committee

The Editor-in-Chief, Roland F. Schoen, M.D., by letter dated June 7, 1968, criticized the method pursued of notifying the various committees of their financial budgetary position each month. Dr. Schoen, in attendance, stated: After listening to and reading about our communications gap, I think that probably my letter is not only ill advised but might be in poor taste. I have no further eomment. RECEIVED.

Uniform Anatomical Gift Act

The National Conference of Commissioners on Uniform State Laws will consider at its 77th Annual Meeting to be held in Philadelphia, July 22 through August 1, 1968, a proposed "Uniform Anatomical Gift Act." A copy is submitted. Comments, criticism or perhaps proposals in connection with this legislation is solicited.

Counsel, Mr. Jacobson, reviewed the content of his letter of July 8, 1968, setting forth the principle differences between the Arizona Act and the Uniform Act. It is concluded that the Commission on Uniform State Laws should be encouraged to complete the draft of this Act. It appears to be a desirable piece of legislation and generally well drawn. There appears no purpose in attempting to replace the present law with this proposed Act until the proposed Act is adopted by the vast majority of States. Until that time, we can refine our present law to: (a) remove certain contradictions and unclear areas existing between it and the other sections of our Code; (b) add certain of the nice innovations included in the proposed Uniform Act; and (c) correct any problems (insofar as they are subject to being straightened out by law) presently being experienced by those in the medical profession currently engaged in the programs affected.

It was regularly moved and unanimously carried that the suggestions and recommendations of Counsel be approved.

MEDICAL ECONOMICS COMMITTEE

Chapter 6, Laws of 1968 — Workman's Compensation

In connection with Chapter 6, Laws of 1968, Workman's Compensation, enacted during the Fourth Special Session of the Arizona State Legislature, it is directed, by motion regularly made and unanimously carried, that the Medical Economics Committee proceed to negotiate further at this time with the Industrial Commission of Arizona as regards adjustment to the existing fee schedule in line with the usual, customary and reasonable fee concept.

Lengthy discussion ensued regarding a further recommendation of the Medical Economics Committee that a mail survey be authorized conducted by it among the various member professional groups within the state seeking information and data regarding charges. Counsel advised that should such a survey be undertaken, consideration should be given to employing an independent agency with possibly the approval of the Industrial Commission, casualty insurors and legislator leaders to assure that on completion, it would be accepted by those interests. This would not be inexpensive, certainly in excess of $5,000.00. Attention was directed to the faet that the House of Delegates of this Association in meeting held April 27, 1968, failed to adopt Resolution No. 5 to institute an annual or bi-annual survey of physicians' usual and customary fees to be collated by geographic areas and by specialties to provide the statistical data necessary to support any negotiations on the subject of fees for medical services with said third parties, because of the costs. Certainly such a survey would be essential if again effort is to be made to again approach the Legislature to achieve the objective; but even more importantly, those doctors who do the bulk of compensation work should be approached to ascertain their feelings regarding the practice and fees being paid and their philosophy as regard working under a fee schedule. Certainly, if the physicians would bill the Commission, their UCR fee, despite the fact that ICA would pay in accord with its schedule, the Commission could then tabulate such information and the answers would be forthcoming. The membership was previously requested to do this; however, from information available, there has been little cooperation to this end.

It was regularly moved and unanimously carried that this Board of Directors turn down the request of the Medical Economics Committee for a mail survey at this time with suitable explanation.

A motion that a resolution be drawn up by this Board to be introduced in the next House of Delegates' session authorizing an independent survey and specifying the amount of money that would be made available to conduct such a survey, failed of passage. It was again expressed that it would be wise to gather together the relatively small handful of doctors who are principally concerned, those who do the bulk of Workman's Compensation injury cases through the years, and find out: (1) Are they seriously dissatisfied with the fee schedule as it now stands; and more importantly, (2) are they seriously dissatisfied with the fee schedule technique?

It was regularly moved and unanimously carried that the Medical Economics Committee be informed that the Board of Directors recommends that before such a sur-

vey be conducted, that it contact the doctors doing the bulk of the Industrial Commission work and determine if they are dissatisfied; if they are dissatisfied, that then they recommend a survey and determine the amount of money it would cost to conduct such survey.

Counsel reviewed his conversation with Mr. Earl Weeks, Counsel representing the Anesthesiologists, regarding constitutionality of the statute as regards the requirement for a fee schedule. Following further review and investigation, it has been determined that a law suit would be a fruitless expenditure of funds with no real hope for success.

Industrial Patients — Freedom of Choice

A Tucson orthopedic physician has expressed concern as regards the lack of freedom that an industrial patient has in seeking out his own physician. The twenty-six member Tucson Clinic has established contractual arrangements with several of the mining companies, principally industrial agencies, whereby that Clinic becomes the physician for the Company; thus, if the patient (employee) is injured on the job, the patient, regardless of who his private physician is, must go to that Clinic to obtain his care; otherwise, he loses his industrial benefits. This abrogates freedom of choice. It is the feeling of the Medical Economics Committee that such contractual arrangements are unethical and not in the best interest of the practice of medicine and freedom of choice concept; therefore, it is proposed to the Board of Directors that the Arizona Medical Association declare such contractual arrangements unethical, and that member physicians be urged to cease and desist therefrom. Considerable discussion ensued. It appears that additional information is necessary before the Board can intelligently act upon this recommendation.

It was regularly moved and unanimously carried that this matter be referred back to the Medical Economics Committee with these comments: that it get in eontact with the Industrial Commission and particularly Dr. Edwards and discuss this whole matter to see what they can come up with.

PROFESSIONAL COMMITTEE

Pre-School Medical Survey of Vision and Hearing

It was regularly moved and unanimously carried that the Board of Directors go on record endorsing the program of the Arizona Ophthalmological Society, without financial obligation; and that screening of pre-school children include both vision and hearing.

Intravenous Administration of Fluids

It was regularly moved and unanimously carried that the proposed "Joint Statement by the Arizona Medical Association, the Arizona Hospital Association, and the Arizona State Nurses' Association on the intravenous administration of fluids (including blood) by Professional Registered Nurses practicing in the State of Arizona" be approved.

Communication Systems

It was regularly moved and unanimously carried that the resolution submitted jointly by Donald F. Schaller, M.D., chairman of the Section on Emergency Care, and Earl J. Baker, M.D., Chairman of the Section on Disaster Medicine, both sections of the Professional Committee, recommended approved by the Professional Committee, proposing a survey of all communication systems operating throughout Arizona to include equipment in existence, its capabilities, needs for the future and budget requirements, leading to a coordination of the communication systems, be approved, without financial obligation.

Air Medical Evacuation System

It was regularly moved and unanimously carried that the report submitted on program evaluation, program management concept and budget, prepared by the Division of Industrial Design and Technology of Arizona State University, associate with the Air Medical Evacuation System (AMES) demonstration program, approved by the Professional Committee, be received, approved and that nominees for appointment to membership on a Steering Committee be provided by this Association.

AHA — Educational Coordinating Committee

Approved the appointment of Howard N. Kandell, M.D. (Phoenix) to serve as ArMA Representative to the Arizona Hospital Association — Educational Coordinating Committee.

Perinatal and Maternal Mortality

Approved an appropriation not to exceed $500.00 to be financed out of the Professional Committee budget, requested by Hermann S. Rhu, Jr., M.D., Chairman of the Section on Perinatal and Maternal Mortality of the Professional Committee, to wrap-up the final report relating to study conducted in the field of perinatal and maternal mortality over the past four years with the aid, cooperation and financial assistance of the Arizona State Department of Health.

SCIENTIFIC ASSEMBLY COMMITTEE

Public Relations Firm

It was regularly moved and unanimously carried that the Board of Directors authorize the Scientific Assembly Committee to employ a public relations firm (or individual) after investigating the public relations firm of John S. Turner & Associates (they to be informed of the criticisms of last year's operation) and other possibilities, providing the fee is satisfactory.

Press Reporters

It was regularly moved and unanimously carried that this Association assume the expenses of newspaper reporters and their wives invited and assigned to cover this (1969 Annual Meeting.)

Scientific Program — Travel Expenses

It was regularly moved and unanimously carried that this Board of Directors authorize payment of the expenses of the Chairman of the Scientific Assembly Committee should it be necessary for him to visit the Medical School selected to confer with the Dean in the development of an appropriate scientific program.

Registration Fees

It was regularly moved and carried that the Board of Directors approve the following registration fees (for the 1969 Annual Meeting):

$35.00	COMPLETE PACKAGE for ArMA members **only** (including two tickets each for the Chuck Wagon and President's Banquet).
25.00	COMPLETE PACKAGE for ArMA members **only** (including one ticket each for the Chuck Wagon and President's Banquet).
25.00	For non-member doctors of medicine and doctors of osteopathy (for the Scientific Sessions — two days).

10.00 Business Sessions (first and second House meeting).
10.00 Scientific Sessions (each day).
2.50 Breakfast tickets (each).
7.50 Chuck Wagon (each).
10.00 President's Banquet (each).

OTHER BUSINESS

Rural and Urban Hospitals — Accreditation

Received for information, the recommendation of the Arizona Advisory Survey and Construction Council requiring additional criteria in determining eligibility for Hill-Burton funds, to be written into the 1969 State Plan for Hospitals and Related Medical Facilities.

Medical and Para-Medical Shortages

It was regularly moved and unanimously carried that the Board of Directors approve the appointment of an Ad-Hoc Committee to make some recommendations and studies of our medical and para-medical shortages, and make some recommendations to the powers that be.

AMA Annual Meeting

Dr. Jarrett reported that probably the most disturbing part of the AMA Annual Meeting in San Francisco was the invasion of privacy — interruption in the proceedings of the opening session of the House of Delegates when two men, a senior medical student from Stanford, representing the Medical Committee on Human Rights, and welfare worker and official of the Bay Area Poor People's Campaign, seized a microphone in front of the podium and insisted on addressing the House.

Dr. Steen reported certain AMA Bylaws changes affecting some of the Sections; called attention to the next Clinical Session to be held at Miami Beach, Florida; reviewed the report of the Committee on Health Care; and commented on the election, especially as pertains to the Board of Trustees, three of the four elected being new members.

MEETING ADJOURNED AT 2:30 P.M.

John P. Heileman, M.D.
Secretary

GOVERNMENTAL SERVICES COMMITTEE

Meeting of the Governmental Services Committee of The Arizona Medical Association, Inc., held Sunday, July 21, 1968, in Suite 201, 4601 North Scottsdale Road, Scottsdale, Arizona, convened at 10:10 A.M., William B. Steen, M.D., Chairman, presiding.

ROLL CALL

PRESENT: Drs. Alexander, Clifton J.; Caldwell, Hayes W.; Dries, Charles P.; Heileman, John P., Secretary; Melick, Dermont W.; Ochsner II, Albert J.; Spendlove, George A.; Stannard, Dale H.; Steen, William B., Chairman; Treptow, Keith R.; Walker, Glen H.

Staff: Messrs. Carpenter, Robert, Executive Secretary; Robinson, Bruce E., Assistant Executive Secretary.

Guest: Mr. Blazek, James J., Administrator, Phoenix Medicare Claims Administration, Aetna Life & Casualty Co.

EXCUSED: Drs. Bishop, Jr., William A.; Dudley, Jr., Arthur V., President; Farnsworth, Stanford F.; Flynn, Richard O., President-Elect; Letourneaux, Stephen A.; McDonald, Richard T.; Reed, Wallace A.

MINUTES

Minutes of the meeting held March 3, 1968, approved as distributed. Minutes of the meeting held April 28, 1968, approved as read.

INTRODUCTIONS

Dr. Steen introduced the new members to the committee as follows: Doctors Alexander, Ochsner, Spendlove, Stannard, Treptow and Walker.

CARRIER — PART B — AETNA LIFE & CASUALTY

Mr. Blazek reported briefly on the activity for the first six months of 1968 as follows:

120,402 checks issued
Average monthly payments of $1,250,000.00
85% of claims are being paid in 15 days or less

Mr. Blazek indicated that the average monthly payments would very likely increase as more and more people become eligible under the program.

Medical Consultant

Mr. Blazek announced that Woodrow W. Scott, M.D. (Tempe) has been obtained as a consultant. Dr. Scott provides medical opinions on claims that are questioned and contacts the doctors to clarify matters that are unclear.

It was suggested that a brief item about Dr. Scott's position appear in MEDICAL MEMOS so that all members are made aware that this is one way the profession can police itself in the Medicare program.

It was regularly moved and unanimously carried that this committee endorse Dr. Scott's appointment and ask that the membership be advised of his position and urging them (ArMA members) to support his efforts on the profession's behalf.

State Medical Review Committees

Mr. Blazek suggested having two state review committees instead of the present six committees.

It was regularly moved and unanimously carried that two medical review committees be established as follows:

1. MEDICAL REVIEW COMMITTEE — NORTHERN SECTION
 Central District (Maricopa County)
 Northeastern District (Apache, Gila and Navajo Counties)
 Northwestern District (Coconino, Mohave and Yavapai Counties)
2. MEDICAL REVIEW COMMITTEE — SOUTHERN SECTION
 Southeastern District (Cochise, Graham, Greenlee and Santa Cruz Counties)
 Southern District (Pima County)
 Southwestern District (Pinal and Yuma Counties)

The chairman, Dr. Steen, is to prepare a list of names for these two committees to be submitted to the Board of Directors for approval. The function of these committees is the same as the original six committees. This consolidation is to improve the efficiency and workability of the committees.

SECTION ON COMPREHENSIVE HEALTH PLANNING

In the absence of Dr. Farnsworth, chairman of the section, Dr. Spendlove reported on the composition of the State Planning Authority as follows:

Wesley G. Biddulph, D.D.S., Chairman
John Carollo — Engineer

Merlin K. DuVal, M.D.
Paul B. Jarrett, M.D.
Robert J. Jensen — Pharmacist
James M. Kilgore, Jr., M.D.
William Wallace LeSueur — Lay member
Stephen M. Morris — Hospital Administrator
Carl Morrison, D.O.
Gladys E. Sorensen, R.N.
Vacancy—Arizona Association for Retarded Children

It was reported that only one meeting has been held to date.

Maricopa County

It was reported that the Maricopa Health Facilities Planning Council has received a $38,000.00 grant for local planning.

SECTION ON ECONOMIC ASPECTS OF MEDICARE

Dr. Caldwell reported on the high cost of medical care in the hospitals. Much discussion ensued on the possible ways of reducing the cost.

One of the reasons for the high cost is the duplication of various tests; i.e., those done in the doctor's office prior to hospital admission and duplicated by the hospital upon admission thus exposing the patient to unnecessary charges and thereby increasing the cost of medical care to that patient. It was pointed out that in many instances the Joint Commission on Accreditation of Hospitals requires this duplication.

It was regularly moved and unanimously carried that it be recommended to the Board of Directors that a resolution be prepared for submission to the AMA urging that the Joint Commission review its position which requires duplication of certain laboratory work upon admission to a hospital when such work has already been performed in the doctor's office prior to hospital admission.

Central Data Bank

It was suggested that the concept of a state-wide computerized central data bank for laboratory reports be explored. It was pointed out that having the initial laboratory test results in the data bank would do away with the need for the existing duplication of tests and costs. It was pointed out that this would be one way the medical profession could lead in reducing the cost of medical care.

SECTION ON MENTAL HEALTH

Keith R. Treptow, M.D., newly appointed chairman of this section, was introduced. A general discussion ensued regarding the function of this section.

SECTION ON OEO PROGRAMS

Clifton J. Alexander, M.D., newly appointed chairman of this section, was introduced. A general discussion ensued regarding the function of this section. It was suggested that Dr. Alexander contact Dr. Philip Dew, former chairman, to obtain background on past actions of this section.

SECTION ON REGIONAL MEDICAL PROGRAM

Dr. Melick reviewed the status of this program pointing out that two area offices have been established. The Phoenix office consists of:

Boyden L. Crouch, M.D., Associate Coordinator for Continuing Education
Miss Margaret Knapp, Nursing consultant and Chief of Nursing Unit
Myron Miller, M.D., Associate Coordinator for Facilities

In Tucson the personnel are:

John Flynn, Administrative Assistant
Dermont W. Melick, M.D., Coordinator
James R. Shaw, M.D., Associate Coordinator for Facilities
Mrs. Mary Opal Wolanin, Nursing Consultant

The function of the two offices is to emphasize that the regional program is a state program and although it originates out of Tucson at the College of Medicine, it has a responsibility to the entire state.

Part of the planning stage has consisted of questionnaires being forwarded to M.D.s, osteopaths, hospitals and dentists. Questionnaires will soon be sent to allied medical groups and to registered nurses. Dr. Melick pointed out that the greatest problem is contacting the "consumer." He indicated that this phase of the survey is being contracted to the U of A Statistical Department. The results of these surveys should give information to help predict what should be done about certain activities relating to certain needs.

Dr. Melick indicated that an operational grant application has been submitted to N.I.H. in Washington, D.C. for a grant in emphysema and chronic pulmonary diseases which falls under the "allied disease" portion of the law. He pointed out that the delay in receiving official word on the application appears to be due to reorganization presently going on in Washington.

Dr. Melick reviewed the present congressional activities regarding the Regional Medical Program indicating that there seems to be enough activity to justify the confidence that this will be an ongoing program even though the present authorization provides for the program through 1970. He pointed out that the appropriations have been reduced, but this was due to the fact that the original appropriations were in excess of what was needed.

Dr. Melick re-emphasized that grant applications must originate at the local level. His staff will assist in every way possible, but the initiative must come from local groups and individuals.

It was stated that the following committees have been set up:

Stroke Committee
Heart Committee

The following will be set up in the future:

Cancer Committee
Respiratory Committee
Continuing Education Committee

Dr. Melick pointed out that Dr. Richard O. Flynn, President-Elect, has recently been elected as chairman of the Regional Medical Program's Advisory Group.

It was indicated that it appears projects are now being started in Flagstaff and Morenci.

SECTION ON TITLE XIX

Pima County Demonstration Project

Mr. Robinson presented Dr. Reed's report to the effect that the State Welfare Commission has turned down the project as developed by Dr. Reed's section. No further action is contemplated at this time.

Meeting with Governor — 6/18/68

At the instigation of Dr. Reed, a meeting with the

Governor was held on June 18, 1968, for the purpose of determining what interest, if any, the Governor and the current legislative leaders had in Title XIX. The following were present at this meeting:

Hayes W. Caldwell, M.D.
Richard O. Flynn, M.D.
William N. Henry, M.D.
John Pritzlaff, Jr.
Wallace A. Reed, M.D.
Paul L. Singer, M.D.
Stan Turley
Honorable Jack Williams, Governor

Dr. Caldwell reported on what transpired at this meeting, indicating that the greatest concern was over who is responsible for the Indians under this program. All agreed that the cost of the program would be prohibitive if the state had to assume financial responsibility for all of the Indians in Arizona. It was reported that Dr. Reed is continuing investigation of this problem.

Discussion ensued on the need to advise the public at large of the fact that ArMA has been so active in developing a Title XIX program for Arizona.

It was regularly moved and unanimously carried that this committee recommend to the Board of Directors that active publicity be sought to make known to the general public the attitude of the Association and our vigorous efforts to establish the Title XIX Demonstration Project, and why the program was not adopted by the State Welfare Commission.

SECTION ON UTILIZATION REVIEW

Dr. Bishop's report dated 7/18/68 was read and discussed. Dr. Bishop recommended that follow-up meetings, similar to the original series, be held this fall. Dr. Bishop will prepare a questionnaire to determine if there is an interest. The committee approved Dr. Bishop's recommendations.

COMMUNICATIONS

Mr. Barry Stone, Assistant Regional Representative, Bureau of Health Insurance, H.E.W., in letter dated June 19, 1968, comments on the meetings arranged by Dr. Bishop. RECEIVED.

OTHER BUSINESS

Public Education

General discussion was held on the possibility of the Association instigating brief TV and radio spots on medical subjects, such as how to handle diarrhea in babies, etc. It was pointed out that material of this type is available through AMA, but the problem is getting the individual stations to cooperate and provide the time. It was noted that these presentations must be kept brief to be well received.

Section on Title XVIII — Part A — Migrant Workers

Dr. Steen re-established the above named section of the Governmental Services Committee and appointed Albert J. Ochsner, M.D., as chairman.

MEETING ADJOURNED AT 12:49 P.M.

John P. Heileman, M.D.
Secretary

HISTORY & OBITUARIES COMMITTEE

Meeting of the History & Obituaries Committee of The Arizona Medical Association, Inc., held Wednesday, July 24, 1968, in the Central Office, Suite 201, 4601 North Scottsdale Road, Scottsdale, Arizona, convened at 7:15 P.M., Roland F. Schoen, M.D., Chairman, presiding.

ROLL CALL

PRESENT: Drs. Kennedy, John W.; Schoen, Roland F., Chairman.

Staff: Messrs. Carpenter, Robert, Executive Secretary; Robinson, Bruce E., Assistant Executive Secretary.

EXCUSED: Drs. Brazie, Walter; Dudley, Jr., Arthur V., President; Flynn, Richard O., President-Elect; Green, John R.; Heileman, John P., Secretary; Kohl, Sr., Harold W.; Sitterley, Jay L.; Young, Roy O.

MINUTES

Minutes of meeting held June 21, 1967, approved as distributed.

ARIZONA MEDICAL ASSOCIATION HISTORICAL COLLECTION

Dr. Schoen led off the discussion by indicating the need to get rolling on the development of the collection. Following much deliberation it was determined that a meeting of the Board of Governors should be held prior to October 15, 1968, for the purpose of:

1. Establishing procedures regarding donations and loans to the collection; and
2. Determining ways and means of effectively promoting and advertising the collection so that doctors throughout the state would be aware of the collection.

It was agreed that Dr. Schoen and Mr. Robinson were to arrange a meeting with Mr. John Gilchriese, Field Historian, University of Arizona, as soon as possible for the purpose of setting up the meeting of the Board of Governors.

MEETING ADJOURNED AT 7:50 P.M.

John P. Heileman, M.D.
Secretary
By Bruce E. Robinson
Assistant Executive Secretary

AD HOC BUILDING COMMITTEE

Meeting of the Ad Hoc Building Committee of The Arizona Medical Association, Inc., held Saturday, July 27, 1968, in the Central Office, Suite 201, 4601 North Scottsdale Road, Scottsdale, Arizona, convened at 3:20 P.M., Robert A. Price, M.D., Chairman, presiding.

ROLL CALL

PRESENT: Drs. Dudley, Jr., Arthur V., President; Dysterheft, Arnold H., Past President; Heileman, John P., Secretary; Nelson, Arthur R.; Price, Robert A., Chairman; Young, Woodson C.

Staff: Messrs. Carpenter, Robert, Executive Secretary; Robinson, Bruce, Assistant Executive Secretary.

Guests: Messrs. Hammerstein, Bill, Associate to Kelly, Frank, M.A.I., Real Estate Appraiser and Consultant.

EXCUSED: Drs. Dew, Philip E., Treasurer; Flynn, Richard O., President-Elect; Landeen, Fred H., Vice-President.

MINUTES

This being the first meeting of this newly appointed committee, there were no minutes submitted for approval.

BACKGROUND

Arthur V. Dudley, Jr., M.D., President, made a detailed presentation on all of the previous activities carried on by the Executive Committee leading up to

the appointment of this Ad Hoe Building Committee.

SITE SELECTION

Discussion was had relative to the sites that have been suggested. Mr. Frank Kelly reviewed in depth the many considerations necessary in selecting a site for a building, as contemplated by this Association.

It was generally agreed that we limit the area of possible site location to the so-called "North Central Corridor." Mr. Kelly was asked to prepare a list of four or five locations within this "corridor" which, in his opinion, would be best for the Association. One of these to be an in-depth evaluation of the building and property located at 1410 North Third Street, known as the Hartford Building.

Mr. Kelly's recommendations are to be ready by Monday, August twelfth, so that Dr. Price can present them to the Board of Directors of the Maricopa County Medical Society at their special meeting scheduled for Tuesday, August thirteenth.

ARCHITECT SELECTION

Discussion ensued regarding the choice of an architect. It was determined that the choice should not be made until after the site was selected. Following the site selection the four firms listed below are to be contacted and interviews held with the committee.

1. Bennie M. Gonzales Associates
2. Guirey, Srnka & Arnold
3. Weaver and Drover
4. Donald B. Schwenn, Architects

OTHER BUSINESS

Next Meeting

It was determined to call the next meeting for 8:00 P.M. on Thursday, August fifteenth, in the Central Office. The following matters are to be included on the agenda:

A. Report on Maricopa County Medical Society Board Meeting
B. Site Selection
C. Architect Selection
D. Plans for the 9/5/68 meeting
E. Building financing

Finances

Mr. Robinson reported that the Building Fund has a balance of $48,967.28, with $5,125.00 coming from members who have forwarded their assessments and $43,842.28 from the student loan trusts.

MEETING ADJOURNED AT 6:05 P.M.

John P. Heileman, M.D.
Secretary

BENEVOLENT AND LOAN FUND COMMITTEE

Meeting of the Benevolent and Loan Fund Committee of the Arizona Medical Association, Inc., held Sunday, July 28, 1968, in the Central Office of the Association, Suite 201, Safari Building, 4601 North Scottsdale Road, Scottsdale, Arizona, convened at 10:15 A.M., Daniel T. Cloud, M.D., Chairman, presiding.

ROLL CALL

PRESENT: Drs. Cloud, Daniel T., Chairman; Dudley, Jr., Arthur V., President; DuVal, Jr., Merlin K.

Staff: Messrs. Carpenter, Robert, Executive Secretary, ArMA; Robinson, Bruce E., Assistant Executive Secretary, ArMA.

EXCUSED: Drs. Boiko, George; Chloupek, William N.; Dew, Philip E., Treasurer; Flynn, Richard O., President-Elect; Heileman, John P., Secretary.

MINUTES

Approved minute of the meeting of the Benevolent and Loan Fund Committee held August 20, 1967.

FINANCES

Scholarship Fund

The 1968 Budget appropriated $5,100.00 to the Scholarship Fund. Expended to June 30, 1968 a total sum of $639.23, reflecting a balance of $4,460.77. The Scholarship Savings Fund No. 127 reflects a balance to date of $14,512.15, which includes a sum of $3,000.00 borrowed from this account, recently returned, the result of the discontinuance of the VNB Trust Account No. 160-04714 (Medical Student Loan Account).

Benevolence Fund

The Benevolence Fund (Savings Account No. 103) reflects a balance as of June 30, 1968 of $14,670.05. The Board of Directors of this Association in meeting held July 14, 1968, account hardship, authorized reimbursement to the families of two members deceased, 1968 dues paid totaling $131.25, leaving a balance in this account of $14,538.80.

SCHOLARSHIPS

Awards

For the purpose of the record, following is listed Scholarships in the sum of $500.00 each granted by mail vote between the period of September 1, 1967 to July 1, 1968 which actions were reaffirmed:

1. Timothy A. Lind (Tucson); graduated U. of A.; attended U. of A. College of Medicine.
2. Stephen Patrick Bailey (Phoenix); graduated ASU; attended U. of A. College of Medicine.
3. Thomas S. Bailey, Jr. (Phoenix); attended ASU; graduated U. of A. College of Medicine.
4. Henry Hughes Kaldenbaugh (Tucson); graduated U. of A.; attended Baylor University College of Medicine.
5. Daniel Lee Neel (Ajo); graduated ASU; attended University of Utah College of Medicine.
6. Timothy C. Kennedy (Tucson); graduated U. of A.; attended Columbia University College of Physicians and Surgeons.

Applications for Review

Carefully reviewed and evaluated each application in hand, the Committee approved and granted the following seven (7) Scholarships in the sum of $500.00 each, subject to the registration of the applicants in approved medical schools or colleges of their choice, September next, as first-year medical students:

1. Barker, George Thomas (Phoenix); graduated ASU; to attend U. of A. College of Medicine.
2. Bowe, Patricia Ann (Tempe); graduated ASU; to attend U. of A. College of Medicine.
3. Jones, William Guy (Phoenix); graduated Loma Linda University; to attend Loma Linda University School of Medicine.
4. Temple, James Terry (Prescott); graduated U. of A.; to attend U. of A. College of Medicine.
5. Weaver, Michael Joseph (Tucson); graduated U. of A.; to attend U. of A. College of Medicine.
6. Francis, David John (Tucson); graduated U. of A.;

to attend Yale University School of Medicine.

7. Wesolowski, David (Phoenix); graduated U. of A.; to attend U. of A. College of Medicine.

Application Incomplete

Thomas L. Embry of Phoenix, applicant for a scholarship, graduated from Phoenix College hoping to attend the University of Arizona College of Medicine this coming fall. He has not been accepted; however, his name appears on the alternate list. His application was likewise carefully reviewed and evaluated.

It was determined that if Mr. Embry is accepted as a first-year medical student (1968-69) by an approved medical school, he be granted a $500.00 scholarship upon registration and entrance.

OTHER BUSINESS

Scholarship Bequest

It was reported that Mrs. Marie B. Mallory (Widow) has provided a bequest to the Scholarship Fund of this Association in her Last Will and Testament. This was arranged through her Attorney, Mr. Alvin E. Larson of Phoenix.

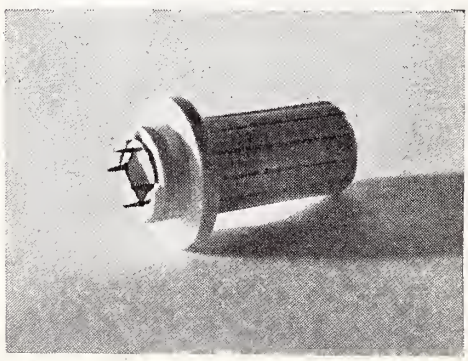
It was determined to recommend to the Board of Directors of this Association that consideration be given the creation of the Mallory Medical Student Scholarship Fund, the Arizona Medical Association, operating through its newly organized Foundation, serving as Trustee.

MEETING ADJOURNED AT 11:35 A.M.

John P. Heileman, M.D.
Secretary
By Robert Carpenter
Executive Secretary

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



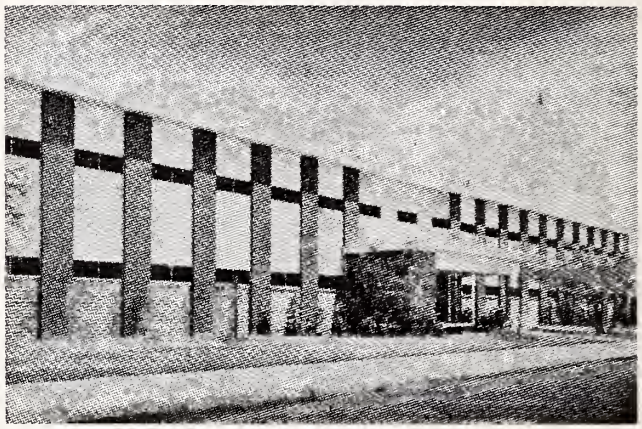
TUBERCULIN, TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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Thomas F. Hartley, M.D.
R. C. Romero, M.D.

ANESTHESIOLOGIST
Sue Boyett, M.D.

AUDIOLOGY
R. Nelson Miller, Ph.D., A.

DERMATOLOGY
Oeie Carl Yarbrough, M.D.

EAR, NOSE and THROAT
Richard Zonis, M.D.

FAMILY COUNSELING
Leo Stein

FAMILY DOCTOR
William B. McGahey, M.D.
John A. Martin III, M.D.

GENERAL SURGERY
Boyd H. Metcalf, M.D.
James T. Chesnut, M.D.

INTERNAL MEDICINE
GASTROENTEROLOGY
Charles Bergschneider, M.D.

OPHTHALMOLOGY
Robert L. Yockey, M.D.

ORTHODONTIST
James C. Toye, D.D.S.

PATHOLOGY
C. H. Strickland, M.D.
Fred C. Schoene, M.D.

PERIODONTIST
J. Richard Loughry, D.D.S.

PHYSICAL MEDICINE
Dennis Harris, M.D.

RADIOLOGY
D. J. Murry, M.D.
M. Herbert Nathan, M.D.

THORACIC CARDIOVASCULAR SURGERY
Carl Impellitier, M.D.

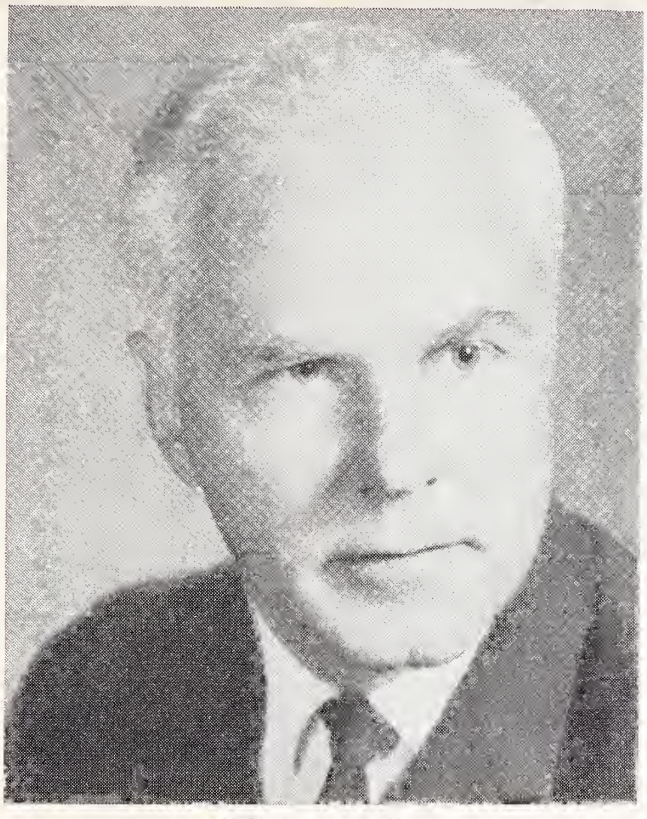
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ARIZONA'S COLLEGE OF MEDICINE ONE YEAR PROGRESS REPORT



MERLIN K. DuVAL, M.D.
DEAN

The September 1967 issue of ARIZONA MEDICINE, in its entirety, commemorated the opening of Arizona's first College of Medicine. It had a very wide and broad circulation and brought distinction to both the College and the Arizona Medical Association. Now, one year later, the editors of ARIZONA MEDICINE felt that it would be interesting to review some of the things that have been taking place in the first year in the new College of Medicine. For the purposes of such a review, we have limited our progress report to those items which apparently have the broadest interest. These include the physical plant and building program, recruitment of fac-

ulty members, the students, the problems of curriculum and accreditation and the graduate training programs.

I. PHYSICAL PLANT

(A) BASIC SCIENCES BUILDING

The Basic Sciences building of the College of Medicine was funded by means of a private gifts campaign which generated approximately $2,900,000 in pledges, all of which was subsequently matched with approximately $4,200,000 from the U. S. Public Health Service. Construction began in the late spring of 1967 and the building was occupied on September 7, 1967. (This didn't leave much "lead time." The first class of students arrived for orientation the following morning and started classes two days later.) Because the building was well designed and constructed this made the process of moving a great deal easier than might have been true under other circumstances. There were, of course, a few of the usual, comical things that one finds in a newly constructed house or building and this was a source of some real amusement. For example, in one room the electrical outlets were 14 feet off the floor. (We have very few students or faculty members who can reach that height without a ladder.) In the lecture hall, the light switches were placed behind the blackboard so that they could not be turned on or off. In another room, there was no door, and if someone had not realized that something was wrong, it might have remained permanently sealed!

Since moving in, the faculty and staff have continued to grow in size and the building has proven to be a very comfortable and satisfying building in which to carry out our work. A short-order snack bar has been opened for the convenience of all of our people and this has made it possible for us to solve the problem of luncheon, inasmuch as we are not otherwise conveniently located with respect to eating facilities.

On November 17, the University held a formal dedication for the Basic Medical Sciences building. The services were held out-of-doors, on a beautiful fall afternoon, and approximately 2,000 people were in attendance. The main speaker was Dr. William N. Hubbard, Jr., President of the Association of American Medical Colleges. The Bureau of Health Manpower, of the U. S. Public Health Service, was represented by its Deputy Director, Dr. Joseph A. Gallagher. Dr. Joseph Volker, author of the ARIZONA MEDICAL SCHOOL STUDY, was also present, together with representatives from his Advisory Committee. Many of the current and past members of the Board of Regents were also in attendance, as was Dr. Arnold Dysterheft, President of the Arizona Medical Association. We were complimented by the presence of many other fine guests and friends of the University who were with us that day. One month prior to the dedication, arrangements had been made for the members of all county medical societies to tour the Basic Medical Sciences building, on either of two separate days. A moderate number of physicians elected to take that opportunity to see the School.

(B) CLINICAL SCIENCES BUILDING

In 1966, the Arizona state legislature authorized the sale of bonds, to be retired by an increase in student fees, for the purpose of meeting the capital construction requirements of the three state universities. Eight million dollars of these bonds were dedicated to the construction of the Clinical Sciences facility and 300-bed teaching Hospital for the developing College of Medicine. After the bonds were sold, the funds were matched with approximately $15,000,000 from the Bureau of Health Manpower of the U. S. Public Health Service. This year, the architects completed the working drawings for these buildings and, late in January 1968, we advertised for bids. On March 14, the bids were received. The lowest bid, from the Del Webb Construction Company, was accepted. After execution of the necessary contracts and documents, ground was broken for the buildings in July. Delays in this process were threatened because of the freeze on federal dollars but the timing of Arizona's application was favorable, with the result that the funds were available to us when we needed them. This is what made it possible for us to start.

The new building will add approximately 550,000 square feet to the 200,000 that are encompassed in the Basic Sciences building. The new addition will be shaped like an H, resting on a solid rectangle. One limb of the H will house the clinical research areas; its contiguous member will house the ambulatory clinic. The other pair of limbs on the H will represent the stacked nursing units that constitute the teaching Hospital. The rectangular base on which the H rests includes administrative space, a cafe-

teria, radiology, the clinical laboratories, the operating suites and the emergency room. It is estimated that construction will take 30 months. This means that the building can be occupied in approximately January of 1971. We would expect that the hospital functions will be activated in stages and that the first patients will be admitted in approximately April of 1971.

(C) COLLEGE OF NURSING

This year, our College of Nursing moved into its own building, for the first time. Until now, the College has been housed in the Home Economics building on the south side of the University campus. Recently, a new College of Nursing building was completed on the Medical School campus, immediately adjacent to the Basic Sciences building. This is the first step toward the establishment of the concept of a "Medical Center" and will make it possible for the nurses to have ready access to the medical library and the patients in the teaching Hospital.

II. FACULTY RECRUITMENT

(A) BASIC SCIENCES

Department heads for the Departments of Anatomy, Biochemistry, Physiology, Pathology and Microbiology have arrived on the campus. Each of these departments has proceeded to develop both breadth and depth, as reflected in the additional recruitment of faculty varying from three to six persons in each department. Our Basic Sciences faculty represents a very excellent expression of those things that are contemporary and exciting in the medical sciences and they will serve as an excellent nidus around which to develop the rest of the Medical School programs.

(B) CLINICAL SCIENCES

The Head of the Department of Medicine has been on the scene since 1965, for planning purposes, but this year the Department began to grow in response to the curriculum requirements of the first class of students. A Chief of the Medicine Service at the Veterans Administration Hospital is on the scene. Leadership has also been identified and attracted to the campus for the Divisions of Neurology, Cardiology and Pulmonary Medicine. The Chairman of the Department of Pediatrics has been selected and a search is now under way in the fields of Surgery, Psychiatry and Obstetrics-Gynecology. We anticipate having the Chairmen of each of these Departments identified within the next six months.

(C) DEPARTMENT OF COMMUNITY MEDICINE

In the discussion of the curriculum, which follows below, further reference will be made to our Department of Community Medicine. However, we have selected a Chairman for this Department. He brings with him the expertise that derives from his having organized and developed a Neighborhood Health Center in South Chicago and he has an excellent understanding of some of the problems that face American medicine relative to the distribution of health services to some of our citizens. The Department of Community Medicine in our School will encompass many of those things which, from the traditional viewpoint, have ordinarily been the province of a Department of Preventive Medicine and Public Health but it will tend to emphasize the problem of the patient who is seeking to gain entry into the health-care system while he is still ambulatory. This will be discussed further, under the topic of curriculum.

(D) DIVISION OF SOCIAL PERSPECTIVES IN MEDICINE

For years, medical schools have professed a concern for the absence of representation in the curriculum of a technique for reinforcing, and even expanding, the awareness of the student to the social, psychological, cultural, ethical and moral aspects of the circumstances that surround both the patient and the practice of medicine. In general, the schools have attempted to accommodate to this recognized need by requiring a broad, liberal-arts background of the pre-medical student. Recently, there has been a positive effort made to introduce some of these topics into the medical curriculum itself. The most popular technique for the accomplishment of this objective has been to assign it either to a Department of Psychiatry or Behavioral Science. Unfortunately, when this is done within a Department of Psychiatry, the emphasis has been flavored by the orientation of the Department to the circumstances of the disturbed patient. When it has been assigned to a Department of Behavioral Science, it has generally tended to become an expression of clinical psychology. In our College, we are going to introduce a new technique for expanding the awareness of the student in these areas. The device will be the seminar and the technique will be to vacate the curriculum for one or two days at a time and, in the liberated

time, expose the students to a continuous session in which four or five prominent figures on the national scene in the fields of ethics, religion, anthropology, etc., review some of the factors that bear on the practice of medicine such as abortion, organ transplantation, death, human experimentation, etc. To carry out this assignment, we have established a Division of Social Perspectives in Medicine.

(E) HOSPITAL ADMINISTRATION

This year, we located and brought to the campus our Hospital Administrator. He has been given the extraordinary responsibility of taking all of the steps that will be necessary to open the doors of a 300-bed hosiptal 30 months from now. The ramifications and complexities of this responsibility are awesome but we have great confidence that he will successfully meet them although we sometimes wish that he had a little more time in which to do so.

(F) PHYSICAL PLANT AND BUSINESS AFFAIRS

All matters pertaining to the Physical Plant of the University of Arizona are managed by a Director and his staff. The sudden addition of a complex set of buildings such as those in the Medical Center has imposed a substantial new load on the Physical Plant Department with the result that a single person has been identified to manage the Physical Plant affairs of the Medical Center. This has proven to be advantageous to all parties involved and we certainly look forward to a continued smooth operation in this area. Similarly, the fiscal affairs of the University, and all of its colleges, fall within the jurisdiction of the Vice President and Treasurer of the University. But here too, the sudden addition of a complex operation such as the Medical School has added a large burden to the existing staff and a single person has now been identified to structure and lead the development of sound fiscal operations within the Medical Center.

III. THE MEDICAL STUDENTS

(A) CLASS OF 1971

The members of the first class of 32 students admitted to this Medical School were introduced on these pages last year. The class has made excellent progress through Anatomy, Biochemistry, Histology, the Neurosciences, Physiology, Microbiology, Physical Diagnosis and the Introduction to Medicine. That's quite an accomplishment for the first year and represents the expression of our "core" curriculum concept. The class has experienced no attrition — all students have made it successfully through the first year and are starting as sophomores this month.

During the course of the year, several of the students were able to hold down part-time jobs on the outside, for purposes of gainful employment but most of them found this not to be an expedient way to use their time while they were in Medical School. It is of interest, however, that the members of this first class dispersed themselves widely over the summer months. Their activities ranged from working among the Indians (with the Christian Medical Society), participating in research fellowships, working in hospital pharmacies, clinical and basic science laboratories, and even in the construction trades. Seven of the original class were married when classes started last year and three more have since taken on that additional responsibility.

(B) CLASS OF 1972

Following the screening of a large number of applicants, we have selected the class of 32 students who will begin their medical studies this month. The class is well balanced and offers a second exciting year as a substrate for the efforts of the faculty. Following this article we have included the photographs of the incoming class members. Twenty-nine members of the class are residents of Arizona and three are non-residents. There are five girls. Ten of the students are from Arizona State University and twelve from the University of Arizona. One has come to us from Northern Arizona University in Flagstaff. Out-of-state institutions are represented as follows: Stanford University — three; and one each from Harvard, Johns Hopkins, University of Montana, Occidental, Pacific Lutheran and the University of Pennsylvania. Five members of the entering class are married.

IV. ACCREDITATION AND CURRICULUM

The process of accreditation of medical schools in American is under the joint jurisdiction of the Association of American Medical Colleges and the American Medical Association. Specifically, a portion of the membership of the Executive Council of the Association of American Medical Colleges joins a portion of the Council on Medical Education of the American Medical Asso-

ciation and, together, they constitute the Liaison Committee. At least once every seven years every American medical school is visited by representatives from the Liaison Committee. The visit usually lasts four days and reviews, in very great detail, all of the details of the operation of the medical school. It culminates in a recommendation regarding the accreditation of the school.

Obviously, this procedure will not fit in the case of a school that is under development. The machinery has been modified for new schools in such a way that the Liaison Committee is contacted early in the planning period and an accreditation survey is requested. In response, the Liaison Committee sends a small team to the campus of the institution sponsoring the new medical school and the team spends a day or two on the grounds evaluating the proposed plan, the backing, and the resources that are available to start the school. If all seems in order, a letter of "reasonable assurance" is issued which says, in effect, that the school will be accredited if it becomes operational and carries out the plans as proposed. Then, every other year, beginning with the fall when the first class is admitted, the new school is revisited and subjected to a more nearly standard accreditation visit.

Arizona's College of Medicine underwent the "reasonable assurance" visit in February of 1965 and received the above described letter shortly afterwards. The second visit occurred in the fall of 1967 at which time a full accreditation report was written simultaneously with the arrival of the first class. The next visit will occur in 1969.

In a new school, the most difficult thing for a survey committee of this kind to evaluate is the curriculum, because all of the faculty is never present, and all of the curriculum has usually not been agreed upon. In another section of this Journal, last month and this month, the plans for the curriculum at Arizona's College of Medicine are spelled out in somewhat greater detail. Briefly, a "core" of basic science and clinical material will be given within a 36 month period. The remaining twelve months will be used to subserve a combination of three purposes: (1) strengthen areas in which the student is weak; (2) broaden the individual student experience in areas allied to his primary interests; and (3) deepen the individual student experience in the areas of his career choice.

Throughout this curriculum, interdigitation of the basic and clinical offerings will be accomplished by several different techniques and devices. At all times, however, there will be a heavy emphasis on the patient and, rather than use the traditional university hospital patient as the primary focal point for the early clinical experience of the student, we will shift our emphasis to the ambulatory patient by using the Neighborhood Health Center of the Department of Community Medicine.

V. GRADUATE TRAINING PROGRAMS

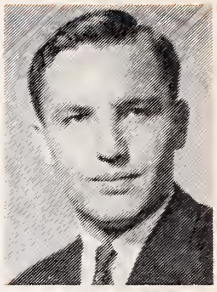
One of the obligations of the faculty of a college of medicine is to educate and train medical scientists for the future. Although the University of Arizona has scattered representatives of the basic medical sciences elsewhere on the undergraduate campus, its opportunities for new educational programs in the traditional medical sciences are greatly expanded with the arrival of the Medical School. The recruitment of the basic science faculty, as well as the design of the Basic Medical Sciences building, have been accomplished in such a way as to permit strong educational programs leading to the Ph.D. degree to be developed in these disciplines.

Within the past year, the first such program to achieve approval was in Biochemistry. Biochemistry has representation on this campus in the Colleges of Liberal Arts and Agriculture. By an excellent administrative arrangement, the Departments of Chemistry in Liberal Arts and Biochemistry in Medicine have joined forces for the purpose of establishing an educational program leading to the Ph.D. degree in Biochemistry. This program is now operational.

The Department of Anatomy does not have an exact counterpart on the undergraduate campus although certain service courses in human anatomy are given for students in medical technology and nursing students. The Ph.D. degree is not given in Anatomy on this campus and, therefore, the Department of Anatomy in the Medical School has proposed a program leading to the Ph.D. degree in Anatomy. This, also, is now operational.

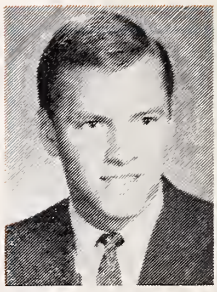
The Departments of Physiology and Microbiology are currently engaged in making preparations for the establishment of programs leading to the Ph.D. degrees in Physiology, and (probably) Molecular Biology, respectively. The preparations should be completed this year and next year the programs will be operational.

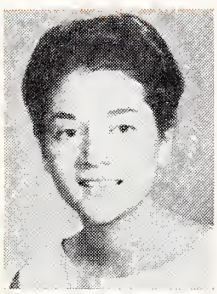
CLASS OF 1972


David R. Allen

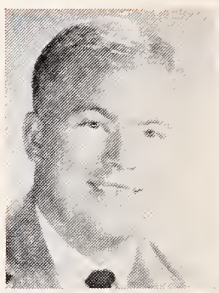

G. Thomas Barker


Thomas A. Baumgartner

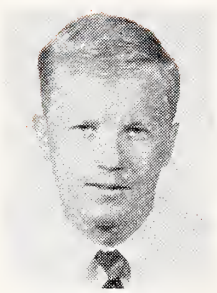

James V. Bounds, Jr.

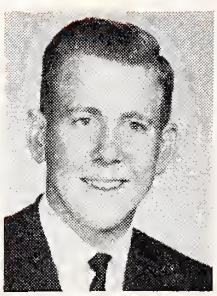

Patricia A. Bowe

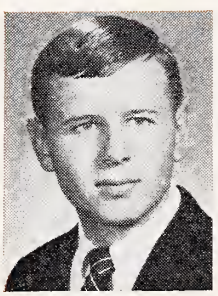

Becky L. Brinegar

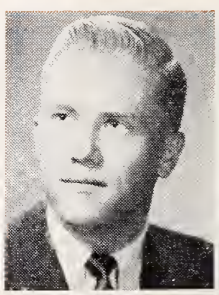

Charles A. Calkins


Patricia A. Dixon


Mel E. Douglas

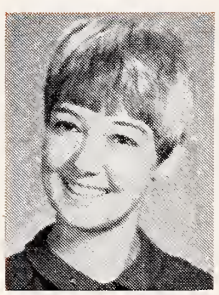

Stephen V. Durand

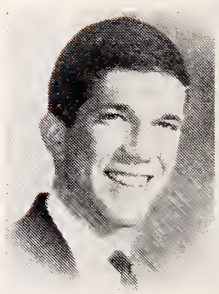

Michael P. Falvey

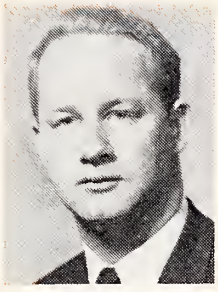

Kenneth R. Fraser


Thomas F. Griffin, Jr.


Arthur F. Haney


Lynn A. Hendricks


Stephen J. Ketchel



Joel W. Kunkel



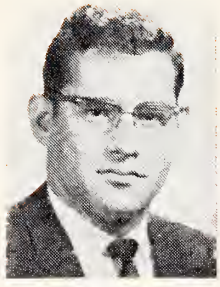
Jeffrey A. Leonard



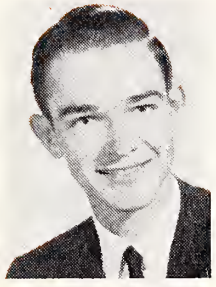
Steve E. Lindstrom



Paul L. Longstreth



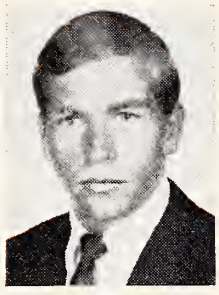
Harold S. Margolis



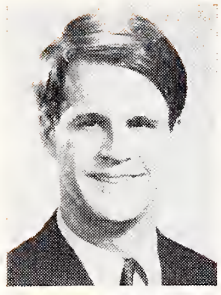
Gary L. Miller



Shirley A. Molenich



John W. Mouer



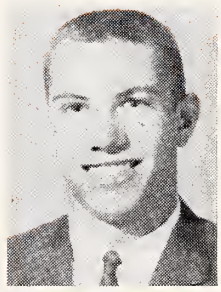
Arthur J. Piccinati



David L. Stoker



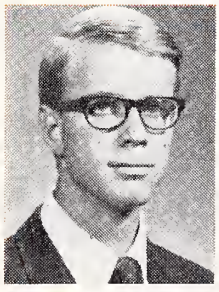
James T. Temple



David B. Thomas



Soleng Tom, Jr.



Michael J. Weaver



Douglas N. Weismann





David P. Wesolowski

THE CLASS OF 1972

DAVID R. ALLEN
University of Arizona
Tucson, Arizona

G. THOMAS BARKER
Colorado College
University of Colorado
Arizona State University
Phoenix, Arizona

THOMAS A. BAUMGARTNER
Pacific Lutheran University
Scottsdale, Arizona

JAMES V. BOUNDS, JR.
Arizona State University
Phoenix, Arizona

PATRICIA A. BOWE
Arizona State University
Tempe, Arizona

BECKY L. BRINEGAR
Stanford University
Tucson, Arizona

CHARLES A. CALKINS
Arizona State University
Scottsdale, Arizona

PATRICIA A. DIXON
University of Missouri
University of Arizona
Tucson, Arizona

MEL E. DOUGLAS
Montana State University
University of Montana
University of Arizona
Tucson, Arizona

STEPHEN V. DURAN
University of Arizona
Mesa, Arizona

MICHAEL P. FALVEY
University of Arizona
Tucson, Arizona

KENNETH R. FRASER
University of Arizona
Northern Arizona University
Tucson, Arizona

THOMAS F. GRIFFIN, JR.
University of Arizona
Sedona, Arizona

ARTHUR F. HANEY
University of Pennsylvania
Broomall, Pennsylvania

LYNN A. HENDRICKS
Arizona State University
Phoenix, Arizona

STEVEN J. KETCHEL
Stanford University
University of Arizona
Downey, California

JOEL W. KUNKEL
University of Bridgeport
Phoenix College
University of Arizona
Tucson, Arizona

JEFFREY A. LEONARD
University of Arizona
Phoenix, Arizona

STEVE E. LINDSTROM
Arizona State University
Tempe, Arizona

PAUL L. LONGSTRETH
Arizona State University
Phoenix, Arizona

HAROLD S. MARGOLIS
University of Arizona
Tucson, Arizona

GARY L. MILLER
Arizona State University
Phoenix, Arizona

SHIRLEY A. MOLENICH
University of Michigan
Arizona State University
Tempe, Arizona

JOHN W. MOUER
University of Arizona
Tucson, Arizona

ARTHUR J. PICCINATI
Harvard College
Scottsdale, Arizona

DAVID L. STOKER
Arizona State University
Scottsdale, Arizona

JAMES T. TEMPLE
Westmont College
University of Arizona
Prescott, Arizona

DAVID B. THOMAS
Johns Hopkins University
Ventnor, New Jersey

SOLENG TOM, JR.
Stanford University
Tucson, Arizona

MICHAEL J. WEAVER
University of Arizona
Tucson, Arizona

DOUGLAS N. WEISMANN
Occidental College
Phoenix, Arizona

DAVID P. WESOLOWSKI
Allan Hancock College
Phoenix College
Arizona State University
University of Arizona
Universidad Autonma Guadalajara
Phoenix, Arizona

DEPARTMENT OF ANATOMY



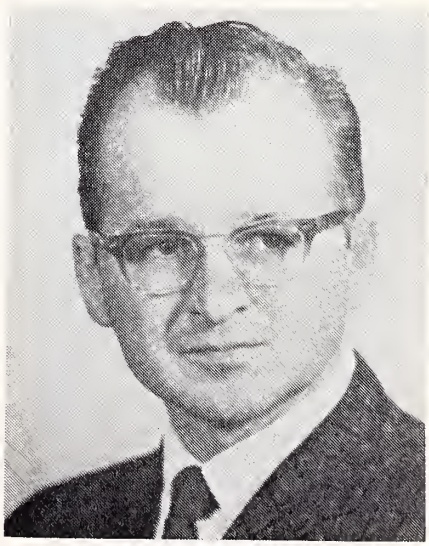
JAY B. ANGEVINE, JR., PH.D.
ASSOCIATE PROFESSOR



LAWRENCE K. SCHNEIDER, PH.D.
ASSISTANT PROFESSOR



PHILIP H. KRUTZSCH, PH.D.
PROFESSOR AND HEAD



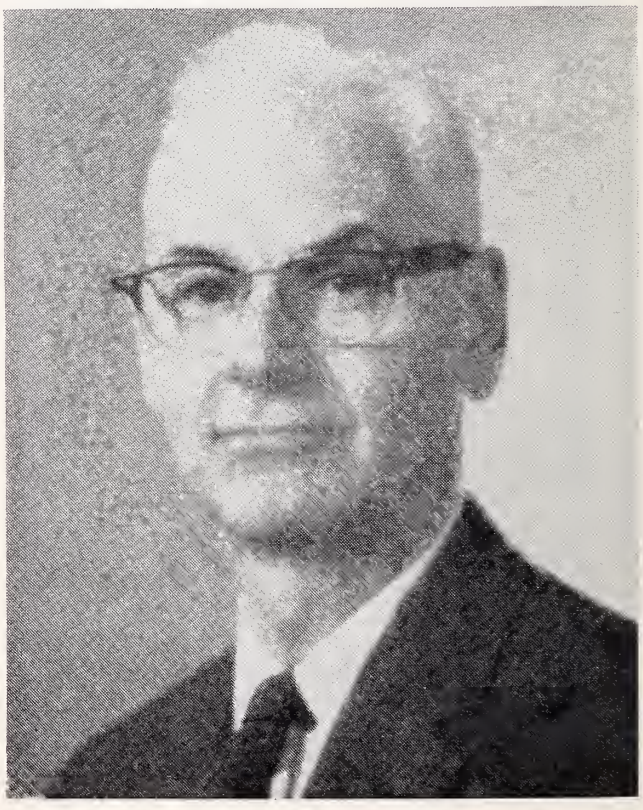
G. ROY HORST, PH.D.
INSTRUCTOR



DIVISION OF ANIMAL RESOURCES

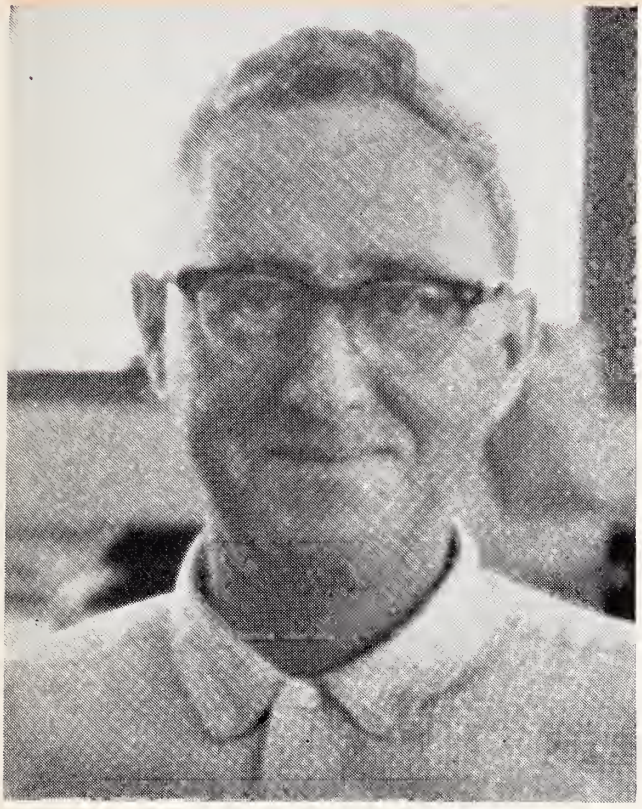
SAMUEL HODESSON, D.V.M., M.P.H.
DIRECTOR

DEPARTMENT OF COMMUNITY MEDICINE



HERBERT K. ABRAMS, M.D.
PROFESSOR AND HEAD

DEPARTMENT OF BIOCHEMISTRY



DONALD J. HANAHAN, PH.D.
PROFESSOR AND HEAD

PROFESSOR HANAHAN'S STAFF ALSO INCLUDES MERLE S. OLSON, PH.D.,
ASSISTANT PROFESSOR, WHOSE PHOTOGRAPH WAS NOT AVAILABLE



CHRISTOPHER K. MATHEWS, PH.D.
ASSOCIATE PROFESSOR



MICHAEL A. WELLS, PH.D.
ASSISTANT PROFESSOR

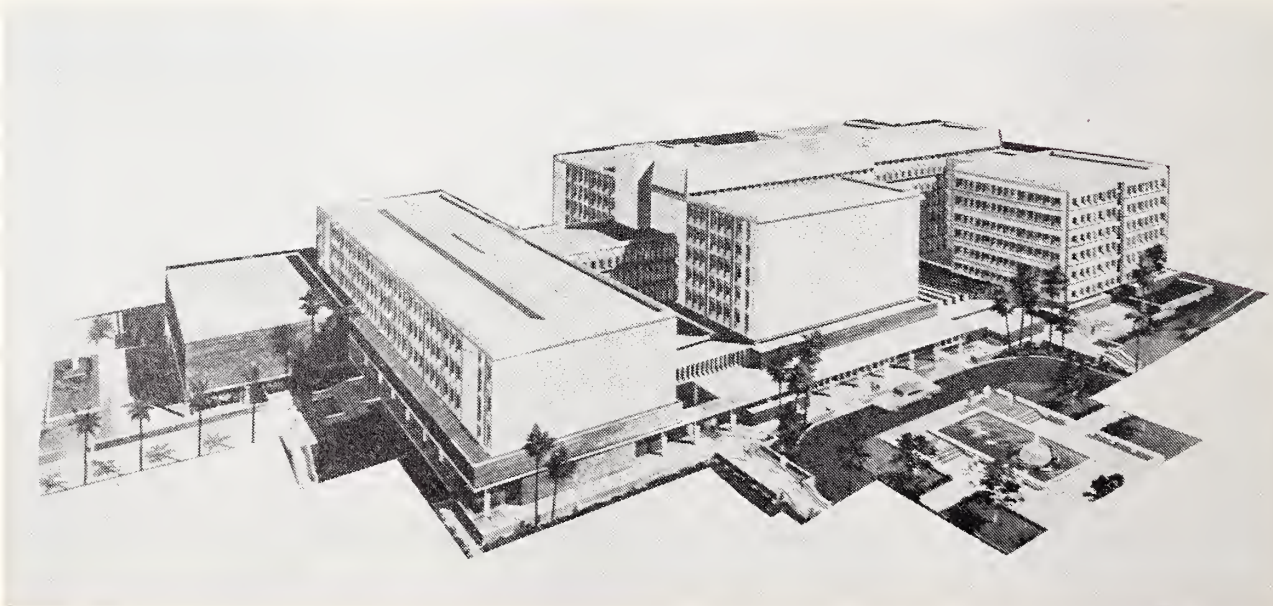


ATHOL L. CLINE, M.D.
ASSISTANT PROFESSOR

HOSPITAL ADMINISTRATION



DANIEL W. CAPPS
ADMINISTRATOR



LIBRARY



THOMAS HIGDON, M.S.L.S.
CATALOGUE LIBRARIAN



DAVID BISHOP, M.S.L.S.
LIBRARIAN

MR. BISHOP'S STAFF ALSO INCLUDES MISS JACQUELINE KASPER, ASSISTANT CATALOGUE LIBRARIAN, WHOSE PHOTOGRAPH IS NOT AVAILABLE.



MISS MIRIAM MILLER, M.S.L.S.
ACQUISITIONS LIBRARIAN



MRS. ELIZABETH HINKLE, M.L.S.
REFERENCE LIBRARIAN



MRS. KATHRYN GLOYD
ASSISTANT REFERENCE LIBRARIAN

DEPARTMENT OF INTERNAL MEDICINE



OSCAR A. THORUP, JR., M.D.
PROFESSOR AND HEAD



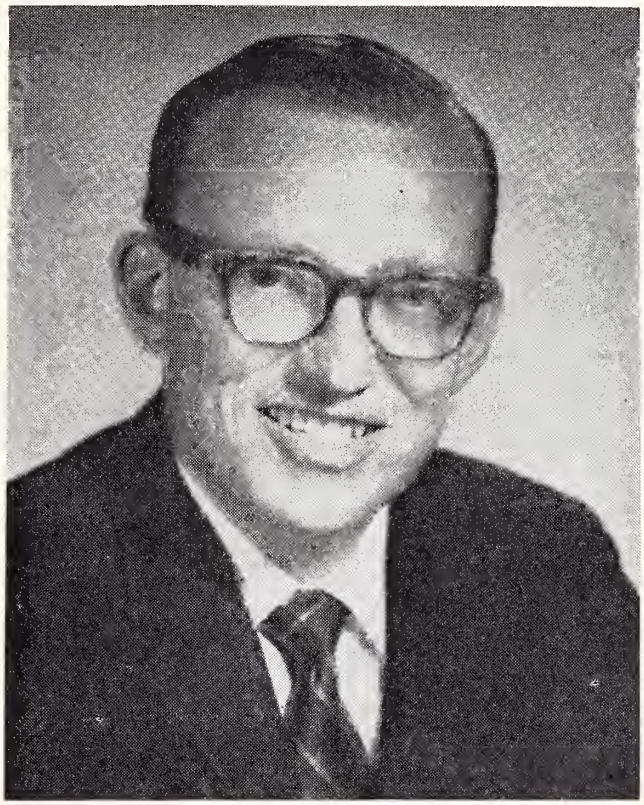
WILLIAM F. DENNY, M.D.
ASSOCIATE PROFESSOR



ALEXANDER H. WOODS, M.D.
ASSOCIATE PROFESSOR



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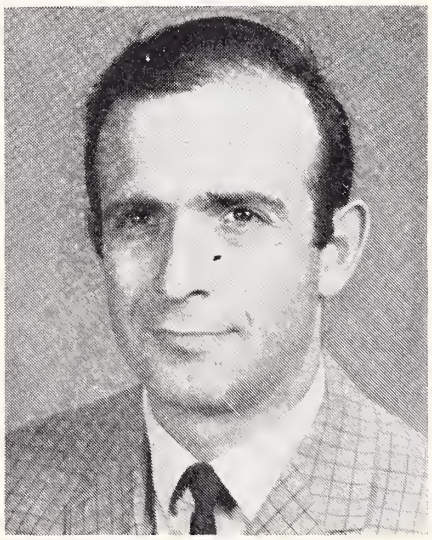
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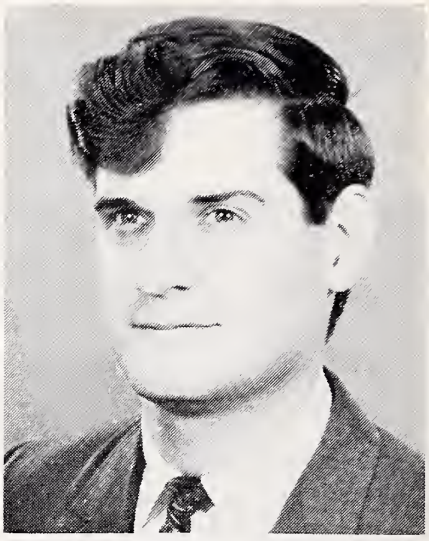


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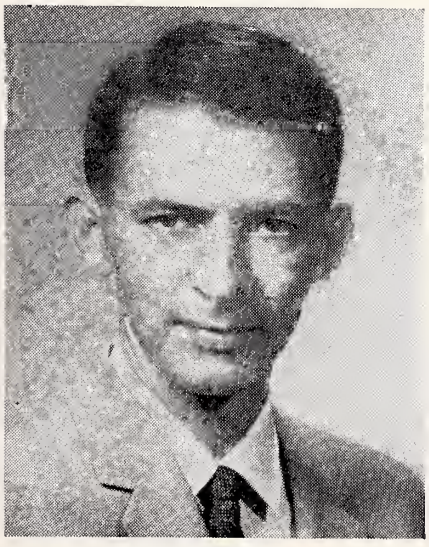


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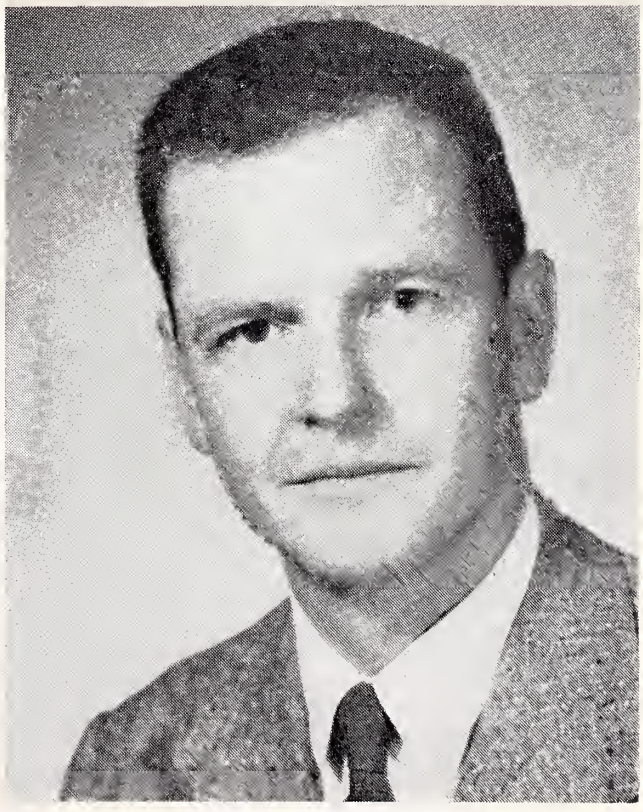


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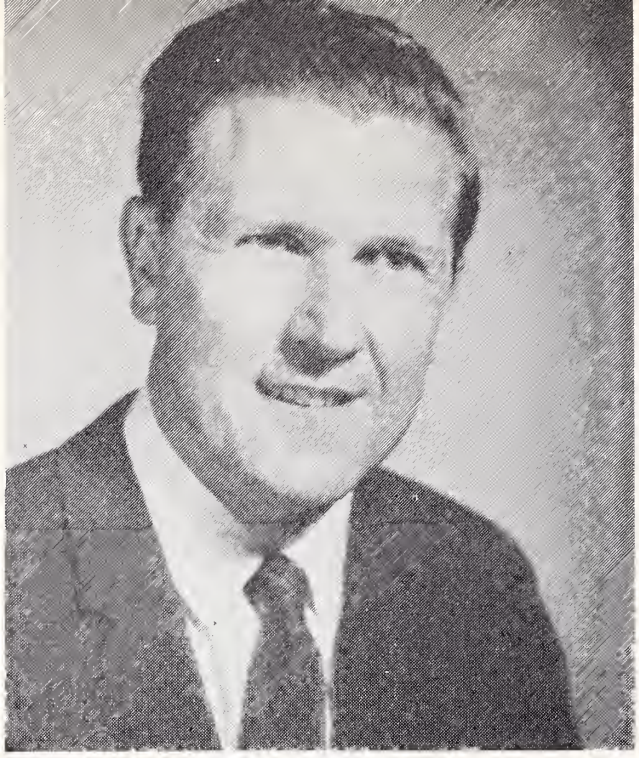


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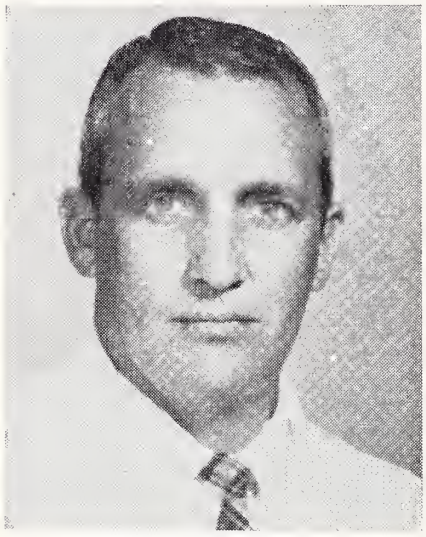


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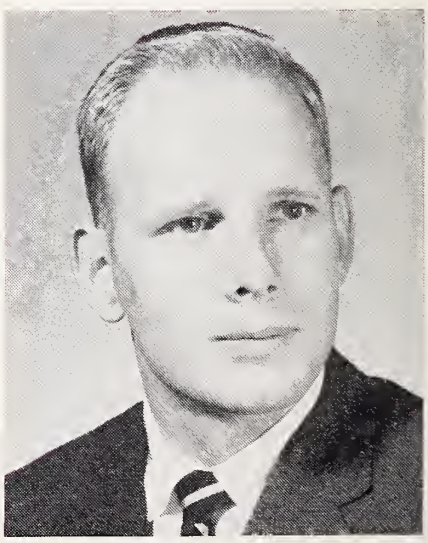
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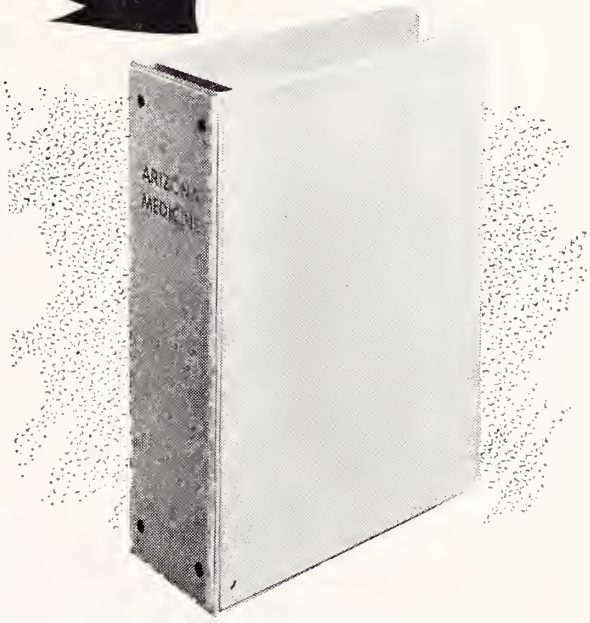
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THE THERAPEUTIC EFFECTS OF A NEW HIGH CALORIC ELECTROLYTE SOLUTION: NORMOSOL – M 900 Cal.



WILLIAM R. PRICE, M.D.

One method of reducing the weight loss and protein catabolism during periods of intravenous feeding is the use of IV alcohol solutions. This manuscript describes in general terms the experience of this diet in the hands of one practitioner.

Starvation resulting from poverty or famine is now a rarity; but the starvation syndrome secondary to disease pathophysiology is frequently observed.

This monograph describes the clinical observations with the use of Abbott Laboratories' Normosol — M 900 Cal (Hi-Cal 900) and discusses the value of this solution in the restoration and maintenance of caloric and protein balance.

Clinical Material

During a twelve-month period ending in October 1967, 118,000 ml. of Hi-Cal 900 Solution (18,000 ml. without electrolytes and 100,000 ml. with electrolytes) were given intravenously to forty-seven persons with a wide variety of injuries and diseases. The patients' ages ranged from 2 to 75 years.

Method of Study

Normosol — M 900 Cal Solution was administered via small peripheral veins, large veins, and in centrally placed venous catheters in volumes of one to three liters per day at rates of 50 to 250 ml. per hour.

Noromosol — M 900 Cal (augmented with other maintenance fluids) was given for as long as eight days; however, all infusion sites were changed every four to five days, or sooner if necessary. All patients were frequently examined for signs of venous irritation, phlebitis, and thrombosis. Observations of alcohol smell to the breath, intoxications, mental changes, and toxicity were recorded, as were daily weights and estimates of caloric and protein balance. Frequent laboratory determinations were made of serum hemoglobin, hematocrit, sodium, chloride, potassium, carbon dioxide combining power, total protein, albumin/globin ratio, urea nitrogen, pH, and liver functions.

The signs, symptoms, physical findings, laboratory functions, complications, and caloric balance in this study group were compared to persons with similar disease states receiving 5% dextrose and water. The comparison was used to establish the indications and contraindications for use, the tolerance, safety factors, and the therapeutic effects of Normosol — M 900 Cal.

Therapeutic Action and Indications for Use

The therapeutic actions of Normosol — M 900 Cal are: a reduction in the incidence and magnitude of negative caloric balance with its resulting protein catabolism; a decrease in the work load of the liver as fat and protein catabolism is lessened; blood urea nitrogen is contained within normal limits as protein catabolism is reduced; a near normal metabolic rate is maintained as the stress reaction of starvation is prevented; a lessening of the edema of starvation as ketosis of fat catabolism is diminished; a near-normal potassium, sodium, and chloride level is main-

tained as cellular destruction, urinary potassium loss, and dilutional hyponatremia and chloremia are minimized; an enhanced rate of wound healing is seen as a more positive nitrogen balance is maintained. In this study, persons receiving Hi-Cal 900 had a weight loss of 0.059 pounds per day as compared to 0.98 pounds per day in persons receiving an equivalent volume of solutions containing five per cent dextrose.

The electrolyte content of Hi-Cal 900 (Sodium 40 mEq/1., chloride 40 mEq/1., potassium 13 mEq/1., and magnesium 3 m/Eq1.) is desirable in that electrolyte loss is a component of most of the previously mentioned conditions and electrolyte balance without fluid overload is required.

Normosol — M 900 Cal was found to be beneficial in re-establishing and maintaining caloric, protein and electrolyte balance in the following conditions:

High metabolic rate and elevated body temperature.

(e.g. peritonitis, pancreatitis, or systemic infections.)

Disturbed gastrointestinal function requiring prolonged intravenous feeding.

(e.g. total or sub-total gastrectomy; ileus following trauma, infection, or surgery; intestinal obstructions or intractable vomiting.)

Excessive utilization or loss of calories and proteins.

(e.g. thermal burns, major surgical procedures, trauma, neoplastic disease, peritonitis, or pancreatitis.)

Elevated blood urea nitrogen secondary to protein catabolism.

(e.g. acute renal failure, massive gastrointestinal hemorrhage, or lower nephrene nephrosis.)

The alcohol content of Hi-Cal (40 ml. per liter of solution) is not only of value when there is a need for an increase in the caloric content of the solution, but is also of value in the following conditions:

When a mild tranquilizing or sedative action is desired.

(e.g. agitated patients, terminal cancer, anxiety states, thermal burns.)

When drug-induced respiratory depression is to be prevented by utilizing the additive effects of alcohol with sedatives, tranquilizers, or narcotics.

(e.g. thermal burns or any person with respiratory system injury or disease.)

When impending or acute delirium tremens must be prevented or attenuated.

(e.g. the chronic alcoholic who requires surgery or presents with trauma or a severe disease condition.)

Tolerance and Safety

Hi-Cal 900 was well tolerated by all patients even when large volumes were given rapidly, and no serious toxic or allergic reactions were observed. No contraindication of use was found, but caution should be used in persons with hepatic cirrhosis, infectious hepatitis, and diabetes mellitus.

In three persons mild peripheral vein irritation was observed; but in each instance, other substances capable of producing venous irritation were being employed and the causative agent could not be established. No complications were observed when this solution was given via a central venous catheter. Phlebitis and thrombosis were not observed; but in a larger study group, it should occur with approximately the same frequency as with other solutions. Administration by clysis is not recommended; but in cases where infiltration occurred the tissue reaction was slight and resolved spontaneously without permanent damage.

Conclusions

Abbott Laboratories' Normosol M — 900 Cal Solution was found to be an excellent source of calories for patients with impaired oral intake. It was a safe and well-tolerated intravenous solution with a small incidence of complications and without observed toxicity.

Significant caloric and protein deficits, ketosis, high metabolic rate, increased liver work load, hypokalemia, edema, and dilutional hyponatremia of the starvation syndrome were minimized; abnormalities of liver function and blood urea nitrogen resulting from starvation were decreased; a sense of well being and sedation was provided; and withdrawal symptoms in the alcoholic were reduced or eliminated.

Weight loss during prolonged intravenous feeding is significantly reduced: 0.059 pound loss per day when Hi-Cal 900 was used as compared to 0.98 pound loss per day in persons receiving an equivalent volume of five per cent dextrose solution.

Normosol-M 900 Cal was supplied by Abbott Laboratories.

NEONATAL HYPERBILIRUBINEMIA AND PHOTOTHERAPY



Milton Semoff, M.D.

Clinical Instructor in Pediatrics,
Tucson Medical Center
Presented at the Pediatric Conference on
January 16, 1968

ANOTHER WORTHWHILE STEP IN THE HANDLING OF HYPERBILIRUBINEMIA IN INFANTS WITHOUT SIGNIFICANT RISK IF HANDLED PROPERLY.

Incantations to Helios . . . The jaundiced infant is prepared. First stripped, eyes bandaged, then placed under a canopy of fluorescent light . . . The yellow color recedes slowly, as if by decree.

Dr. Robert J. Cremer, and others, in the Lancet of May, 1958, first reported their observations and experiments with light and bilirubin.[1] Noting that the bilirubin in serum faded on exposure to light, they exposed infants to sunlight. Jaundice quickly faded from the exposed area but persisted in the shaded area. Next a source of artificial light was devised. This therapeutic approach to neonatal hyperbilirubinemia has been used in England, France, and Brazil. In the U.S.A., the first controlled study was reported May, 1967, by Dr. Jerold F. Lucey at the joint Atlantic City meeting of the American Pediatric Society and the Society for Pediatric Research.[2] The last week of September, 1967, the Tucson Medical Center built its first light cradle, and we now have three in operation.

A quick review of the physiology of bilirubin will aid in the comprehension of the various attempts at therapy with neonatal hyperbilirubinemia. Phagacytosis of the erythrocytes yields iron, which is stored in the liver, and bile pigment. The latter is formed from hemaglobin by oxidative-reduction reactions to verdoglobulin, to biliverdin, and to bilirubin. The bilirubin is bound by albumin and carried to the liver where it is conjugated with glucuronide and excreted into the bile. In the intestine with further reduction to stercobiligen, some are excreted as coprochrome (brown), some are re-absorbed into the circulation then to the liver and kidney where they are excreted as urobilinogen.[3]

The liver of the newborn is marginally capable of converting 15-17 mgm of insoluble unconjugated bilirubin derived from the normal daily degradation of 0.5 gms. of hemoglobin to the soluble non-toxic form of bilirubin diglucuronide and clearing it from the liver. The inadequate development of the glucuronomide conjugating system slowly increases in efficiency during the first week through the first month. In like manner, an early limited capacity of the liver to excrete bilirubin may also result in hyperbilirubinemia.[4]

Consideration of the many factors involved in the state of hyperbilirubinemia allows us to appreciate the importance of the albumin binding capacity, the glucuronyl transferase enzymes, the entero-hepatic shunt, and before birth, the placenta.

Jaundice is rare at birth because of the efficiency of the placenta and the entero-hepatic shunt. Clinically, jaundice in the newborn can usually be noted at 4 mgm% bilirubin. Some degree of neonatal jaundice is present in 60% of all term births with a greater incidence in premature infants. Maximal bilirubin concentrations are reached by the third to fourth day (5-7 mgm% and decrease rapidly below 2 mgm% by the seventh day. Physiologic jaundice is considered to be due to the immaturity of the glucuronide-conjugating system.[5]

Kernicterus is the heart of the bilirubin controversy. The level of bilirubinemia necessary to produce encephalopathy is related to many associated factors, such as hypothermia, acidosis, hypoglycemia, asphyxia, drugs and starvation.[6] The latter causes an increase in the concentration of non-esterified fatty acids which compete for the albumin site.[14] The neurologic damage that results from kernicterus is permanent. Since kernicterus does not appear in the immediate post-natal period, and becomes obvious only with excessive amounts of bilirubin, it should be considered a preventable disease.[10] Autopsies on prematures show an incidence of 2-10% kernicterus.[3] The infants that do not die in the newborn period have rather characteristic motor and usually intellectual disability in later life, often with impairment of hearing.[7] Recently Dr. Thomas R. Boggs, and others, used data on 23,000 infants to show a positive relationship between increasing neonatal hyperbilirubinemia and the incidence of low motor and/or mental scores regardless of birth weight and of distress at birth as measured by Apgar scores.[8] Dr. Albereti, in Great Britain, demonstrated that the hearing mechanism is particularly vulnerable to hyperbilirubinemia. Two hundred children with severe Rh incompatability at birth were evaluated after 8 years and significant hearing loss was found in 9%. Hearing impairment correlated closely with birth weight and the presence of jaundice. Random samples of 300 children representing 10% of all affected children (mild to severe) during this period showed a 3% loss of hearing.[9] An incidence of 12-20% of dangerous serum bilirubin levels (over 14 mgm%) in untreated premature non-erythroblastotic infants has been reported.[8] It would be of clinical importance if this group of infants could be followed with hearing tests.

Neonatal hyperbilirubinemia (jaundice) during the first twenty-four hours must be considered Rh incompatability until proven otherwise . . . , then ABO incompatability, and more rare cytomegalic inclusion disease, and congenital toxiplasmosis. On the second and third day jaundice is usually physiologic jaundice. From the fourth through the seventh day the most likely cause is sepsis. . . . The congenital diseases of syphilis, toxiplasmosis, and cytomegalic inclusion disease may also be implicated. Jaundice after the first week involves: breast milk (excess pregnandiol), glucose 6 P-D deficiency; congenital atresia of bile ducts; homologous serum hepatitis; idiopathic dilatation of the bile duct; herpetic hepatitis, galactosemia, congenital hemolytic anemia (spherocytosis), or crisis of other hemolytic anemias such as thalassemia, sickle cell anemia, hereditary non-spherocytic anemia, or hemolytic anemia due to idiosyncrasy to drugs and other substances.[3]

Dr. Hughes lists the following factors which are involved in the deficiency of glucuronyl transferase: Immaturity, Genetic, Disturbances of CHO Metabolism, Hypoxia, Dehydration, Intestinal Obstruction and Pyloric Stenosis, Excess Pregnandiol (breast milk), Drugs, Sepsis, Cretinism and Mongolism.[5]

The most frequent causes of hyperbilirubinemia may be summarized as, Immaturity, Hemolytic Disease, and Sepsis. . . .

Therapy: In severe erythroblastotic disease anemia and hypovolemia must be considered along with hyperbilirubinemia. Treatment now precedes delivery. Dr. Liley introduced amniocentesis and intra-uterine transfusion. Others have attempted hysterostomy with indwelling peritoneal catheters in the fetus so as to give repeated transfusions.[11, 12] Post-partum exchange transfusion is yet our most potent therapeutic tool for the treatment of a rapidly rising serum bilirubin and/or a severe anemia. Anti-Rh gamma globulin has been successful in preventing sensitization when given to previously unsensitized Rh negative women during the post-partum period.[13]

Progress is being made with prophylactic measures in jaundice of the non-erythroblastotic neonate. Albumin binding drugs (sulfa compounds, salicylates, caffeine, large doses of water soluble

K, and certain antibiotics, like Kanamycin) are to be avoided during pregnancy. Early feeding of the neonate with glucose, milk, or activated charcoal either dilutes or absorbs the pigment interfering with the entero-hepatic shunt.[8] Better understanding of immaturity has resulted in better thermal control, early control of hypoxia, acidosis, dehydration, and hypoglycemia. Most important, from this work has evolved the concept of the Neonatal Intensive Care Unit for the high risk infant. Because of this need *now*, the Tucson Medical Center was one of the first community hospitals to open a Neonatal Intensive Care Unit without governmental assistance.

Phototherapy: For many years laboratory workers have known that serum bilirubin exposed to light will fade. Dr. Cremer's classic report in 1958, was the first attempt to understand and put this mechanism to practical therapeutics. He and his fellow workers noted that the bilirubin (serum) was highly photosensitive in vitro. They further showed that under the action of light, bilirubin undergoes photo-oxidation or dehydrogenation to biliverdin or some intermediate products. Bilirubin (van den Bergh indirect pigment) was noted to be two to three times as photosensitive as was conjugated bilirubin (van den Bergh direct pigment). Next, they exposed jaundiced infants to sunlight, then to artificial light. The blue white fluorescent canopy gave light of very high intensity in the region of 420-480 mu without any dangerous ultraviolet or x-ray components. They suggested that phototherapy may be used in controlling the serum bilirubin levels in the jaundiced premature infant.[1] Further trials were carried out by investigators in Europe and South America.[8, 20] Blondheim and Kaufman expressed the concern of many clinicians as to the toxicity of the derivatives of bilirubin produced by light, i.e. an ultrafilterable pigment.[15] Broughton and his group in London noted that Ernster had demonstrated that bilirubin uncoupled the oxidative phosphorylation of brain and liver mitochondria, and suggested this was the basis of its toxicity.[17] They examined the possible toxicity of the photochemical decomposition products of bilirubin by studying their effect on oxidative phosphorylation. They used liver and brain mitochondria of Gunn rats to demonstrate that light treated bilirubin had no effect on oxidative phosphorylation. Eleven infants with physiologic jaundice were irradiated with blue white light with a resulting fall of bilirubin concentration averaging 2.9 mgm% after eight hours of treatment. They also suggested the use of the ten 2 foot 20 watt lamps that we now use.[16] August, 1967, Dr. Lucey wrote that precisely what chemical reactions are involved, we do not know, but tracer studies in vivo have shown that the colorless products of such photo-lysis are excreted very rapidly. They appear to be non-toxic.[8] Mr. Perryman, the biochemist, involved in the original 1958 report stated at a recent interview that they had not been able to find any toxic effects from the breakdown products after light therapy.[18]

Dr. Charles Warren of St. John Hospital, Chelmsford, England reported that about 30% of their premature infants develop hyperbilirubinemia and about 50% of these can be managed with light therapy.[19]

Dr. J. F. Lucey's controlled study at the University of Vermont has virtually turned the light on for us. Twelve to 20% of their non-erythroblastotic premature infants showed dangerous or potentially dangerous serum bilirubin levels (over 14 mgm%). In 50 untreated infants the incidence was close to 20%, while of the 50 light treated infants *not one* had reached the potentially toxic serum bilirubin level. Treated infants were placed under the light at 12 hours of age and kept there until 144 hours of age.[8]

Jaundice of the premature (other than Rh and ABO) can in most cases be treated safely and successfully with phototherapy.[21] Many clinical observations and studies attest to the safety of light therapy. The equipment can be built and tailored to need in the hospital carpenter shop. We built our light cradle so that it would fit easily over an Isolette. Installation of wheels made it easy to move for infant care. The same light cradle may be used over a bassinette. Some cover has been recommended for the infant's eyes. We have used elastic bandage. (See Figure 1)

Our experience at Tucson Medical Center has verified the world-wide enthusiasm for phototherapy. We have not placed all of our prematures under the light for six days as did Dr. Lucey; however, we recommend that prematures be placed under the light at the first recognition of jaundice. Our average exposure is three days. The rapid bleaching of color helps convert dis-

believers. Good contrast may be shown by keeping the diaper in place over night and the yellow panty effect is striking. On several occasions we have found it necessary and convenient to put two Isolettes under one light cradle.

Premature twins (344674 & 344675) at birth weighed 1474 gms. and 1632 gms. Jaundice was noted on the third day. The serum bilirubin was 8.7 mgm% and 9.5 mgm% respectively. They were given phototherapy for three days at which time their serum bilirubin levels were 6.7 mgm% and 8.0 mgm%.

We suggest phototherapy after exchange transfusion. In several cases we feel that we have prevented re-exchange. Baby Boy (345200) O+, Mother G^8P^7O-; no history of prior Rh sensitivity; cord serum bilirubin 5.1 mgm%; 24 hrs. 17.4 mgm%; post exchange 7.9 mgm%; 4 hrs. 13.4 mgm%; 28 hrs. 14.1 mgm%; 36 hrs. 16.8 mgm%; 60 hrs. 15.5 mgm%; 84 hrs. 10.9 mgm%; 108 hrs. 4.0 mgm%.

With several infants we were in a more comfortable position as we followed serum bilirubin levels without exchange transfusion but kept them under the light cradle. Baby Boy (345670) A+; Mother G^8P^7O+: no prior history of ABO sensitivity weak positive Coombs; cord serum bilirubin 2.6 mgm%; 20 hrs. 8.3 mgm%; 28 hrs. 9.7 mgm%; 2nd day 12.1 mgm%; 3rd day 13.9 mgm%; 4th day 8.8 mgm%; 5th day 6.1 mgm%; light cradle for entire period.

Phototherapy must be individualized to each particular infant with neonatal hyperbilirubinemia. The rate of serum bilirubin rise and the dangerous or potentially dangerous levels reached will decide if this therapeutic modality can be used alone or in conjunction with exchange transfusion. Phototherapy for the jaundice or prematurity is the treatment of choice.

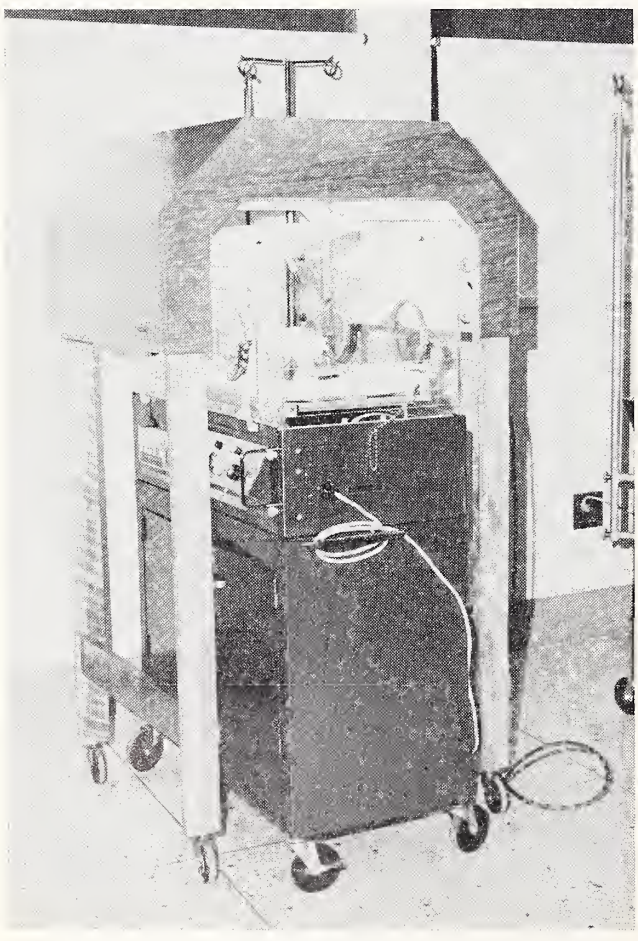


Figure 1
Designed and built by Mr. Pete Brolund, carpenter. Photography by Mr. Tom Burke, medical photographer. For further details consult with author at the Tucson Medical Center.

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PRESIDENT

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Did you move since the last general election?

If you answered "no" to question #1 you neglected your duties as a citizen of this country. If you answered "yes" to question #2 – re-register.

Little do we doctors realize what a political force we are. If properly organized and politically active we could influence over two million patients a day. However, most of us let "Joe" do it. "Joe" in this case is your Arizona Political Action Committee (ArMPAC). ArMPAC is a bipartisan group of Professional men (M.D.s and para-medical fields) and their wives. With 1968 being a general election year, "Joe" needs more help than ever. Are you a member? Is your wife a member?

Member of ArMPAC or not, Democrat, Republican, or Independent, please become politically active. Encourage your patients to do the same. Whether you wish to be active or passive be sure to vote (and encourage others to do likewise).

THE CURRICULUM — PART II



Dean's Page

In an earlier presentation of the newly proposed medical school curriculum the concept of reduction of the "core" content of the basic and clinical sciences into a thirty-six month period was discussed. The "free" year that is provided by taking such a step can then be used to strengthen areas of individual student weakness, add to the breadth of his background, or deepen his exposure in areas that are pertinent to his personal career choice.

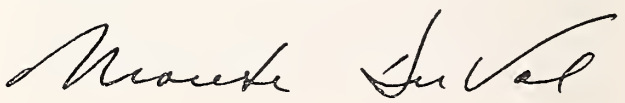
To make it possible to foreshorten the instructional "core" this way involves teaching all of gross anatomy and biochemistry in the first semester of school. All histology, physiology and microbiology are covered in the second semester. Pharmacology is covered in the first half of the second year while anatomical pathology and clinical (laboratory) pathology are spread over the entire second year. This has been possible because each discipline has responded to the general faculty appeal that they have been covering somewhat more ground than most medical students need (or perhaps retain) and that it would be preferable to emphasize basic principles and instruction in the techniques of problem solving, rather than content, this early in the career of the medical student. Then, at a later point in the curriculum, those students who would benefit most can be brought back to particular basic sciences. This is what the "free" fourth year permits.

Meanwhile, as an aid to the basic sciences, clinical relevance is featured whenever and wherever it seems appropriate. As a start, students are exposed to patients in the first week of their freshmen year, and continuously thereafter. And while they don't learn diagnosis or pathology at that stage of their development, they do start becoming sensitive to the settings in which illness occurs, its meaning to the patient, the interacting forces between a patient and a physician, the rudiments of history taking, etc.

And although this continues throughout the first year, it is in the second year that a truly closer look is taken at the realities of illness. For this we will use our Department of Community Medicine and its Neighborhood Health Center. This combination is designed to analyze and meet the health needs of a circumscribed, clearly defined population group. This means of introducing the student to clinical medicine offers what we think are several advantages. First, the student sees people who are ambulatory and who are still a part of their respective family units. Second, he sees illness at its beginning and is therefore more alert to the value of preventive medicine. Third, he sees whole people with specific problems rather than focusing on the problems themselves. In other words, he sees the point at which medicine and people first come together.

In the third, twelve-month period the student will be exposed to basic, in-hospital clerkships. There has been a great deal of interesting discussion on this point. Some hold the view that bedside experience in a university hospital is essentially a useless undergraduate experience because it bears no relationship to the realities or actualities of medical practice. Others take the opposite view; namely, that the university hospital offers the most advanced and futuristic view of medicine's capabilities and to deny this exposure to the medical student would be to short-change his educational experience.

Our position is between these viewpoints. We believe that the university hospital constitutes the best laboratory ever devised for the study of human physiology and pathology and that one need not restrict its enormous potential to interns, residents and staff physicians. On the other hand, the university hospital should not be allowed a curriculum emphasis for the undergraduate student that is disproportionate. In other words, hospital-based experience should be treated in perspective to the rest of the broad spectrum that is medicine. Thus, we confine our basic clerkship to a single year and balance it with the ambulatory patient experiences in the Neighborhood Health Center.





A TIME TO LEAD

MALCOLM C. TODD, M.D.

President (1968-69), California Medical Association.

Presented at the 97th Annual Meeting of the California Medical Association House of Delegates, March 26, 1968, San Francisco.

We are here today not to recount our past achievements but to provide true leadership in an era charaeterized by swiftly changing patterns of medical practice.

The participation of our county society presidents here today has special meaning for me. For they, along with the elected delegates of the California Medical Association, represent the essence of local leadership which is the foundation of all that our association has been or will be. In a rapidly changing political and social environment, one thing remains constant: the qualities which a people will seek out to find its leaders. The local leaders who have joined us here exemplify these qualities: knowledge, integrity and compassion.

I would be remiss if I did not take this opportunity to point to another physician who, for the past year, has been charged with the grave responsibility of leading this association. A man who has unselfishly devoted untold hours away from his family and practice to respond to the multiple challenges facing medicine during a particularly turbulent time — President John G. Morrison. We also honor his lovely wife, Mary Lou, who exemplifies the great contribution which our wives so generously make.

As I look about this auditorium, I am again struck by the fact that California medicine is rich in leaders — strong men whose scope of knowledge is vast enough to enable them to reach far beyond responsibilities to the individual patients they serve men capable of responding to the larger health needs and problems of this state with bold, new constructive approaches to the delivery of health care.

And in my opinion that is the essential task facing this association today. We must translate individual leadership into a true leadership role for the California Medical Association. Truly, gentlemen, we have giants in this day.

It has been said that medicine is blessed with a great legacy — a vigorous present and a challenging future. But simply to recount our scientific vietories of the past — aseptic surgery, smallpox, diphtheria and thyroid vaccine, penicillin and antibiotic therapy, poliomyelitis eradication, blood transfusions and blood banks, radioisotopes, organ and tissue transplants — is not enough. Physicians can no longer cling to a distinguished record of scientific achievement. We also must act now to gain leadership in the larger arena of social and economic change. When we fail to exert this leadership, others who are less

qualified do it for us.

Society changes, regardless of our actions. It is our job and our duty to bring our collective knowledge, understanding and energy to bear on this change, so that it may truly be in the best interests of patient care. An apt illustration of how society has changed regarding medical care is brought out by McGray's thought-provoking book, *Ferment in Medcine.* It notes a dramatic change in the thinking of our society. When a person is seriously ill or injured, the cry is no longer, "Call the doctor," but rather, "Take him to the hospital." Now it is perfectly clear that a hospital is not capable of taking care of anyone. But this and other erroneous concepts are becoming increasingly imbedded in the minds of our people.

John Galsworthy once said, "If you don't think about the future, you can't have one." Therefore, we must *do* some thinking. We must project our planning and programming for a better and healthier California of tomorrow.

Where are some of the essential areas in which the leadership of 24,000 California physicians must be exerted?

Legislation

The passage of the dramatic health legislation of the 89th and 90th Congresses heralded a new era of medical practice. Like it or not, we are now living in a time when public responsibility is replacing our traditional individual responsibility for health care, because of political expediency.

In 1965 the California Legislature approved welfare legislation known as Medi-Cal. It was a promising effort to bring the same high quality of health care to our needy citizens as is available to others of the public. Today the Medi-Cal program is in trouble. AB 5 went into effect without proper preparation, with unrealistic fiscal projections, and with poorly defined administrative details. CMA still believes in the basic concepts behind Medi-Cal. Our task is now to take the lead in retaining the basi components of the program without over-burdening it, and at the same time develop creative new approaches to solving fiscal and other problems which have arisen.

The CMA strongly advocates a prepayment insurance program for comprehensive health services as provided under the law for Title XIX recipients. We feel that the program could best be administered by Blue Shield with our peer review system, with monthly premiums paid by the state government, and a provision for coinsurance payment for those category II patients who are not truly indigent.

Further, in resolving these problems we must implement a proper functional definition between skilled nursing home services and custodial or residential care. We recognize that residential care constitutes a social problem, and it must necessarily be dealt with, but not from Medi-Cal funds.

Medicare

Medicare has helped many over-65 citizens, especially those with prolonged or catastrophic illnesses, and for this help we are grateful. But we knew it would cost the taxpayer too much money. We warned that it would be difficult to administer, and we knew it would be inflationary. In less than two years, time has proven that we were right.

Regional Medical Program (Public Law 89-239)

Public Law 89-239 is commonly known as the bill concerned with heart disease, cancer and stroke. California's Regional Medical Program has completed the planning-grant stage and is now entering the phase of securing operational grants under the law. Examples of postgraduate education programs include coronary care units, angiography tracings, video tape programs, cancer registries and computer analysis of electrocardiograms. Eventually this program will probably be merged into Comprehensive Health Planning. But, for the present, we must be vigilant that these programs do not become coercive, and that they do not propagate at the expense of smaller, non-urban communities.

Comprehensive Health Planning (Public- Law 89-749 and 90-179)

The emergence of federally-financed coprehensive health planning represents a new approach which cuts across nearly all aspects of the provision of personal and environmental health care. While we would have wished that such a program had been initiated by the private sector rather than government, this legislation provides us with a vital opportunity for leadership. By involving ourselves in the local implementation of this program we can lead rather than be led, we can guide, rather than be directed, and we can improve our health care system according to

the values we know to be paramount, rather than having bureaucratic programs developed for us.

Cooperation between physicians and government is insuring that this legislation will not disregard established patterns of personal medical care. In choosing involvement rather than withdrawal we can retain the freedom of the individual physician to make his own decisions, guide the way to more effective provision of health care and, at the same time, renew public confidence in medical leadership. Both the California Medical Association and the American Medical Association recognize that planning, organization and distribution of health facilities and services are a primary responsibility of organized medicine. Even though we may not approve of the philosophical basis for such legislation, it is indeed necessary that we become involved in the broad scope of planning for the proper utilization of public funds where need does exist.

Comprehensive Health Planning and the many other government health care programs now under way point to a need for closer and broader relationships between the providers of medical care, patients, and the government. I would suggest that an advisory committee on health care for Californians be established. Such an advisory board would be composed of persons of influence in the fields of medicine, education, hospital administration, business, labor, religion, social work, minority groups, communications media, law, voluntary health agencies and others. Working with state government, such a group could give long-range direction to the future of health care.

The Profession's Role in Quality Health Care

Should any of you feel that physicians have no part in defining, in setting standards, and in applying quality, you should have attended the National Health Forum's meeting in Los Angeles last week. Over 800 were in attendance including members of the United States Public Health Service and the Department of Health, Education and Welfare, social workers, labor leaders, representatives of the Veterans Administration, of voluntary health agencies and of the health insurance industry, and a few scattered practicing physicians who almost forcibly acquired invitations — all telling us what quality is and how it is to be obtained.

If any lesson can be learned from that conference, it is that the medical profession must not only continue to be responsible for monitoring the quality of care in hospitals, but to expand these efforts to the physician's office, laboratories, rehabilitation units and all institutions in which they provide services or supervise the activities of other members of the health care team.

Not only must they be concerned about the criteria for evaluating the services they perform, they must also begin to look at the outcomes.

To those of us in California who have been involved in the past several years in the work of our Committee on the Role of Medicine in Society, these discussions came as no surprise.

We had anticipated this development in our examination of the parameters and elements which we felt contributed to the definition of quality care, and also when applied might suggest some kind of index which could ultimately be developed to enable us to judge the quality of medical care. These parameters include competence, availability, motivation, effectiveness, efficiency, and satisfaction. The elements, of course, are first the patient, the physician, the health team, facilities and equipment, plans and programs, and financing.

The role and involvement of the consumer played an important part at this conference. I should like to point out that the increasing involvement of the consumer as exemplified by his participation in Regional Medical Programs and Comprehensive Health Planning further suggests that we must begin to take the initiative in involving the consumer in the assessment which I have just described, so that we will be able not only to demonstrate what we are doing, but also to benefit from the suggestions, experiences and expectations of the patient.

I would urge all county societies to study the third Progress Report of our "Role Committee," and together with representatives of the allied health professions start using these parameters and elements as a basis for their evaluation of the various factors contributing to the total spectrum inherent in quality assessment of health care.

Health Manpower

We must continue to give increasing attention to the health manpower problems facing California — through the Health Manpower Council and through special efforts such as our recent program directed at the maldistribution of man-

power, which means shortages in rural areas of the state, and some depressed areas of our cities.

Of necessity the physician is the key figure of the health manpower team. Our affluent society is making demands greater than the sources of manpower can provide. In order for physicians to provide quality care, they must learn to utilize fully the health care team we now have and to look toward the development of other kinds of needed personnel. I suggest we give consideration immediately to the establishment of an action program for training of a new paramedical profession — a "physician's assistant" — under the guidance of medical society sponsorship. In addition, we must give leadership in the training and recruitment of additional nurses, Licensed Vocational Nurses, technicians, and all members of the health team. A state workshop on the definition, composition, and function of the health team would be most timely.

Emergency Medical Care

We must take the lead in revamping present systems so that the right care is available at the right time. CMA's newly established committee on Emergency Medical Care has a vital role to fill in this area. We must take the individual responsibility to insure that the profession does not abdicate practice on weekends, on Wednesday afternoon, or after 5 p.m. We must be sure that coverage is available 24 hours a day, every day.

Drug Abuse

The CMA has developed working committees on the timely subject of the misuse of drugs and will give positive leadership in this regard. I would urge the establishment of additional courses in health education to the junior high and high school curricula to include drug abuse, narcotics, LSD and marijuana, the effects of alcoholism and cigarette smoking, sex education and personal health care.

Definition of Life and Death

Perhaps the traditional response by physicians and attorneys toward life and death needs reexamination and reevaluation. New techniques, procedures, and materials have added to the prolongation of life. The remarkable heart transplants have created new attitudes as a milestone, and a significant breakthrough was reached in December 1967. I propose the formation of a highly professional state commission of many disciplines to evaluate and assess the impact of organ and tissue transplants. This commission would make thorough studies of the ethical, legal, moral and technical implications of such advances, and develop guidelines for their application. Changes in consent laws will be necessary. Someone must make judgment on transplants and the definition of life and death, and this can only be the physician.

Professional Liability

As I have traveled about the state this year, malpractice insurance and professional liability is the subject of high priority among our physician members. Physicians are concerned, and they expect leadership from the CMA and county medical societies. We have reported on our survey and you are in receipt of the results of this malpractice study. We are working in liaison with the California Hospital Association and the California Bar Association. We have testified before the legislature. We have introduced legislation into the State Assembly that will assist members of our profession as well as the public. I urge you to support this current pending legislation.

Further, I propose that a joint panel review board with the California State Bar be established immediately to assess cases with poor results to determine if there was malpractice or to judge the validity of a potential case.

The Young Psysician

Our Committee on the Role of Medicine in Society is now engaged in a long-term study of attitudes of medical students, interns and residents, and young physicians. These young men have developed new concepts. We hope to bring these young men into our official family of the CMA. I am proposing an "apprentice" membership of students, interns and residents known as "SIR" membership. This will allow them to become an integral part of the association, and to participate in the medical society activities and in committee work of hospital medical staffs.

Medical Education

Medical education is probably the profession's greatest challenge. Medicine is a science continually changing, always reaching upward toward a world free from the fear of illness. But this can only be achieved by training young men and women to provide quality medical care — the best care possible for our people. The leaders of the CMA simply are not satisfied with the results of our medical education. We are not

satisfied with the curricular results, and we believe that we must do better. We must come to grips with the problems of today and the future. We must voluntarily upgrade our own individual educational standards by postgraduate education. This can be done through the CMA program of Continuing Medical Education. If all physicians will do this voluntarily, there will be no need for compulsory relicensure as proposed in the report of the President's Commission on Health Manpower.

Reporting continuing education could be made a requirement of the hospital medical staff acceptance. I would urge our medical staff executive committees to give consideration to this means of obviating any need for compulsory reexamination.

American medicine is educating many celebrated scientists, researchers and academicians, but far too few physicians — doctors who take care of people when they become ill. The deans of our medical schools, and particularly their faculties, have one basic responsibility, and that is to train doctors to take care of people when they get sick. Research and academic interests are necessary, but the obligation of our medical schools is the production of new physicians.

In 1950 there were 78 medical schools in the United States, four of them in California. In 1967 we had 94 medical schools in the United States, eight in California. Nine new ones will be added in the nation by 1971. By the mid '70s we will be graduating 10,000 physicians each year compared with 7400 in 1966. The physician population stands at 306,000 with 210,000 in active practice. But this is not enough. We have our own "brain drain" in this country — the constant and progressive decrease in the ranks of practicing physicians as members of the profession are siphoned off into research, teaching, and administration. It is ironic that President Johnson and his administration have successfully aggravated the shortage of medical personnel — the National Institutes of Health take 10 percent of the new physicians into research and the Public Health Service takes many young doctors into that organization.

The Federal Government has allowed proliferation of federally financed research projects, so that the number of physicians in full-time practice has decreased at the rate of almost one percent a year. Naturally the question is asked, how can we correct some of these deficiencies in developing medical personnel and faculties? Medical education is unique because the required ratio of instructors to medical students is four or five times greater than is required for other professions. Then, our medical school laboratories are not utilized effectively. While they should be perhaps operated from 8 to 12 o'clock and 1 to 5 each day, they are utilized only two or three hours a day. Finally, consideration should be given to conducting classes eleven months of the year instead of eight or nine months.

Yes, our CMA has taken many significant actions, and it has developed a substantial number of creative programs which have earned for us a reputation of constructive leadership.

Physicians are a very sophisticated group — highly educated and justifiably proud of their individual ability and independent philosophies, but if we are to be successful in holding our own against opposing forces, unity of purpose is essential. Lack of concert may often bring out weakness and our downfall. But if we achieve a unified front, the crevices of weakness cannot divide us in our endeavors.

May I offer special recognition to members of the Woman's Auxiliary — our wives. Their promotion of health careers, health education, the "gems" program and many community health services activities is laudable.

I could go on and on enumerating CMA's concerns — environmental health, relationships with the clergy, mental health and retardation, occupational health, alcoholism, group practice, poverty programs, disaster medical care. Because medicine is a noble profession with a great legacy and a heritage that we should and will pass on. If we have weakness, and if we lack perfection, it is because the majority of us are busy just taking care of people when they get sick, and do not have time to become professional politicians and protect our own interest. So I trust that my remarks on this occasion are such that I have been able to project the true image that "doctors are people who care."

With the help of the members of this House, of the Council, of our commissions and committees, of our county society officers, of all of our doctors and our excellent staff, the CMA will move forward. Because it is truly a "Time to Lead."

SHOULD THE FDA CONTROL MEDICAL DEVICES?

"I SEE NO CLEAR NEED"

HON. ED REINECKE (R—CALIF.)

Over the past two decades, biomedical and electronic engineers have brought to medicine a wide range of sophisticated and sensitive diagnostic and therapeutic equipment. There is no doubt that the instruments and devices of today's laboratory, hospital, and office have contributed substantially to bettering the health and well-being of the American public.

Knowing that there are potentials for abuse in any rapidly expanding new field, the medical profession has rightfully assumed a major role in evaluating the safety and efficacy of devices. Since the practitioner ultimately bears responsibility for his patients, no one is better qualified than he to judge the reliability or suitability of specific devices for specific cases.

If the physician is responsible to the patient, the industry is responsible to the practitioner. The device manufacturers must meet the exacting standards demanded by the doctors who use their products. In my judgment, this partnership between medicine and industry has been outstanding. In cases of device quackery, the FDA has the authority to remove from the market "devices" which are clearly frauds, hazards to public safety, or unreliable.

But new medical device legislation is now pending in Congress. The FDA, although already armed with considerable controls, has proposed that elaborate machinery be established for pre-market clearance of nearly every device that is not designed for diagnostic or veterinary uses. Also, it would establish standards regarding the properties, composition, and performance of devices not requiring pre-market clearance. A few existing devices would require no standards — but the Secretary of HEW still would oversee them and take action at his discretion. Moreover, a member of the FDA has assured me that diagnostic instruments will come under the agency's aegis in the near future.

As a legislator, I feel that the proponents of this bill must answer to my satisfaction three questions. First, is there a need for the proposed legislation? Second, how would it operate? And, finally, is this the best way to achieve the desired ends?

no justification for passing the Administration's device legislation at this time. There is no clear need for this legislation. We do not yet have the information we need to evaluate any legislatve proposal that would place cumbersome and somewhat dubious controls on the device industry and on the freedoms of the health professions. Is the public's health and safety so threatened that Federal laws are required to clear devices entering the market-place? Or has the FDA in its zeal to control quackery — a zeal which we all applaud, I might add — confused legitimate devices with fakes? The medical equipment that the proposed legislation would most stringently affect includes those devices that are relied upon by health professionals, not the miracle machines promoted by charlatans and fake healers.

Nor does the Administration have the facts to substantiate its proposal. The language, for example, is vague and ambiguous; the categories for pre-market clearance, broad and imprecise. Yet, even though answers offered by the FDA

to questions put to it by practitioners and manufacturers are unclear, confused, and sometimes even contradictory, the Administration is still certain of one thing: It says the time to act is now. This is despite the fact that many of the problems in the device field haven't even been explored.

Study Commission Proposed

It is for this reason that I am sponsoring legistlation calling for a National Device Commission to determine the need for and extent of Federal regulation of devices, and to study the best way to develop and implement device standards. Let me say, though, that my own investigations have revealed that device manufacturers and health professionals, working together, do carefully weigh the effectiveness and reliability of specific medical instruments. But there may be sound justification for the industry and the professions to expand these voluntary efforts by setting up meaningful standards so that all devices put on the commercial market will be safe, reliable, and effective.

No one — except perhaps members of the FDA — pretends to have a solution to the problems involved in establishing device standards. And no one — except perhaps members of the FDA — pretends to be able to explain how these standards can protect the public's safety and better than it is now protected by the professional and competitive arrangements of the private sector. But I can assure you that Congress will not act hastily. Legislative action can be justified only after evidence has been gathered and evaluated in depth.

Source: MEDICAL-SURGICAL REVIEW, a Chapman-Rheinhold publication.

Future Medical Meetings

SYMPOSIUM ON VIRUS DISEASES

September 28-29, 1968

Del Webb's TowneHouse
Phoenix, Arizona

Sponsored by

The Arizona Chapter of the American Academy of Pediatrics
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GUEST SPEAKERS

Charles A. Alford, Jr., M.D.,
Professor Pediatrics
U. of Alabama Medical School

Max D. Cooper, M.D.,
Professor Pediatrics
U. of Alabama Medical School

Henry G. Cramblett, M.D.,
Professor and Chairman
Dept. Medical Microbiology
Ohio State Medical College

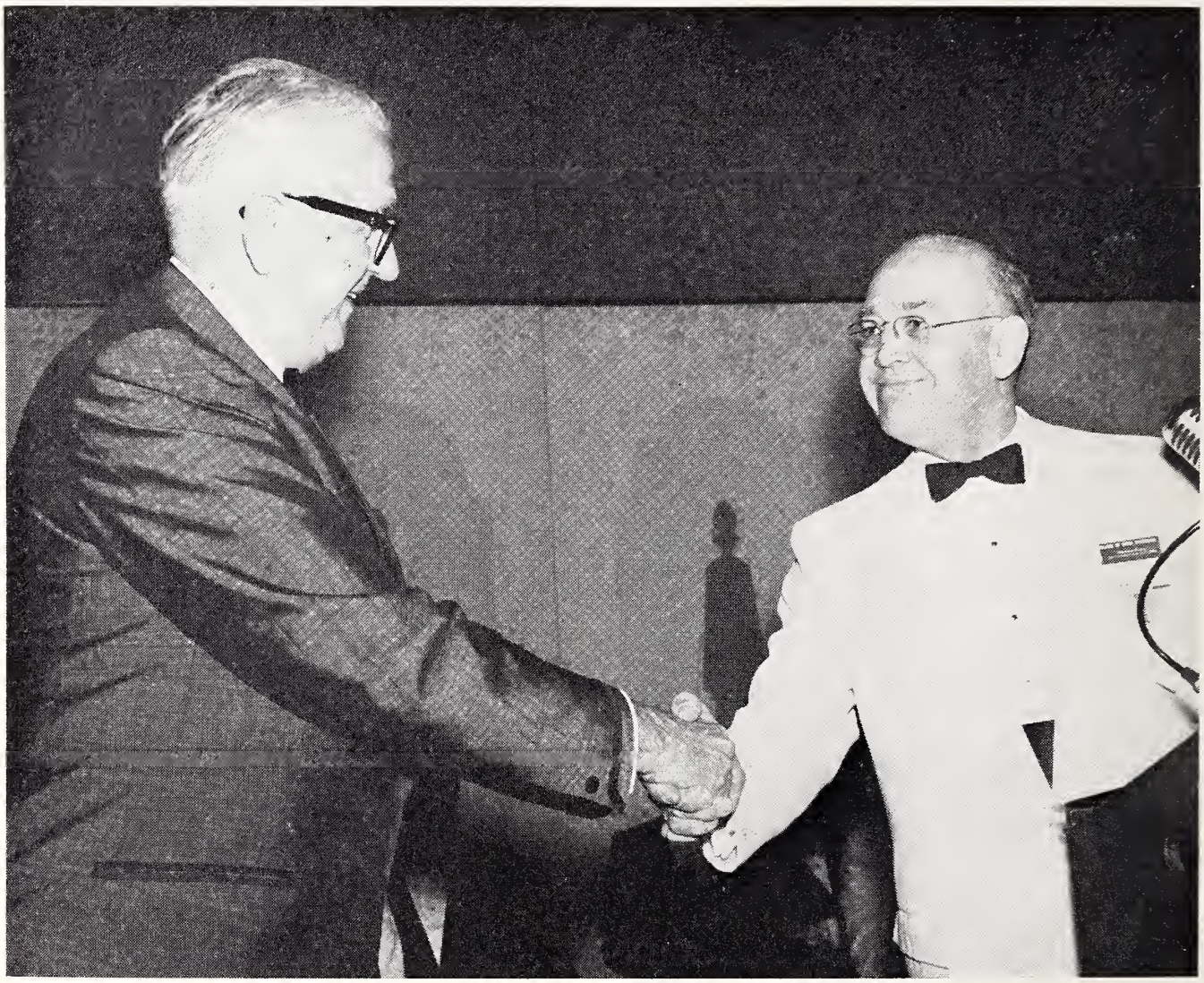
Harris D. Riley, Jr., M.D.,
Professor Pediatrics
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Joseph W. St. Geme, Jr., M.D.,
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UCLA School of Medicine
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Topics Of Current Medical Interest



Dr. Howell Randolph of Phoenix, Arizona, immediate past president of the American College of Chest Physicians, shown (left) receiving congratulations from Dr. William E. Adams, president of the College, upon receiving a Master Degree at the convocation ceremony held during the 34th Annual Meeting of the College in San Francisco in June. Dr. Adams, who conferred the degree, is Assistant Director of the American College of Surgeons.

THE NEW INDUSTRIAL COMMISSION OF ARIZONA

WALTER V. EDWARDS, M.D.

In coming months the medical profession will be supplied with more detailed information regarding policies and procedures which will affect physicians and injured workman as they are developed. Our purpose here is to provide a condensation of the portions of a new Workmen's Compensation Law which should be of some interest to physicians as citizens, if not as therapists.

Direction of the State Workmen's Compensation Fund and adjudication of all claims under the law are presently the responsibility of one agency, the present Industrial Commission of Arizona. After January 8, 1968, two new agencies will do the same job.

Among other assorted duties relating to labor laws, and claimant agencies, accident prevention, self-insured employers, physicians and attorney's fees, the new Industrial Commission with five members appointed by the Governor for staggered five-year terms will also have the power and duty to:

1. Process all claims under the Workmen's Compensation and Occupational Disease Laws.
2. Adjudicate second-injury disability.
3. Fix monthly wages in lost time cases.
4. Determine loss of earning capacity.
5. Commute awards to lump sums.
6. Employ hearing officers and upon request, review decisions of hearing officers.
7. Process all reopening petitions.
8. Process request for autopsies.
9. Determine propriety of faith healing.

The State Compensation Fund, competing with private insurance carriers, will be directed by a board of three policy-holders appointed by the Governor.

All carriers including the State Fund will process claims without an order of the Commission if they accept the claim. The employee must report to the employer, the employer to his insurance carrier company, and the physician must report to the employer, insurance carrier, and the Industrial Commission. Within fourteen days after receiving notice from the employer the carrier must either deny the claim, or commence payment of benefits. (Editorially it can be presumed that this provision will expedite acceptance of many claims and payment of benefits, but also will increase the number of claims denied.)

Reopening petitions will be filed with the Industrial Commission with supporting medical evidence. The Commission will notify the carrier who must either deny reopening or commence payment of benefits within two weeks.

The law specifically provides that no employee may leave the state, while under medical care, without written approval of the Industrial Commission.

The amendments further provide that nothing shall prevent a workman from relying, in good faith, on treatment by prayer through spiritual means in accordance with the tenets and practice of a recognized church or religious denomination by duly accredited practitioner thereof, if the Commission does not object thereto.

Under the Occupational Disease Law, although benefits are improved, the law was changed little with the exception of the addition of radiation illness as a designated occupational disease along with others previously enumerated. The maximum weekly compensation to a claimant covered by the OD laws remains forty dollars.

AMA Concern About Physicians Supply Dates Back 50 Years

POLICY: A newspaper reporter recently asked the president of a state medical society why the American Medical Association had ignored the growing shortage of physicians until a year ago. The prevalence of this notion is hard to understand. The fact is that the AMA's concern with the problem of maintaining an adequate supply of physicians for the health needs of the nation can be traced back for at least half a century. As long ago as 1919, for example, the AMA House of Delegates recognized an increasing demand for physicians and call for improvements in medical education to meet the demand.

Again in 1922, the House of Delegates urged expansion of medical schools, construction of new schools and increased financial support of medical education, noting that "the tendency of medical colleges to limit their enrollments is causing some anxiety lest well qualified students will be unable to secure admission to acceptable medical colleges."

In 1951 the House of Delegates stated that the AMA "has no desire to limit the production of properly trained physicians to serve the American people. The policy of the Association is to assist and encourage any responsible group or institution endeavoring to create new facilities or expand existing facilities for the training of physicians . . . The Assocation does not attempt to regulate the size of the national student body in medicine. The number of students admitted . . . is determined by . . . each school, in accordance with the school's educational philosophy and its own judgment of its educational resources."

Only once in the last 50 years has the AMA suggested that the medical profession was overcrowded. That was in 1933 in the midst of the Depression.

But for the last quarter of a century the policy of the AMA has been that more physicians were needed. This policy has been reflected in pronouncements by the House of Delegates and the Council on Medical Education and in statements by AMA officers. Ten years ago, in 1958, the AMA again was urging medical schools to expand enrollments and to relax geographical restrictions on admission of new students.

In the past two years, the shortage of physicians has become increasingly more critical because the demand for health services has risen faster than the increase in facilities and personnel. There are several reasons. The American people are more knowledgeable about medicine, its progress and its benefits. They request more services because they know their value. They also are increasingly more affluent and they are willing and able to spend more on their health. The phenomenal growth of health insurance, easing the financial burden of illness and injury, has influenced the increase in demand. The U. S. population is rising and demand rises with it. A multitude of federal health programs have suddenly poured billions of dollars into an already overstrained health care system, increasing the demand and compounding the manpower problem. The number of physicians in government service has also contributed to the problem. More than 26,000 physicians — exceeding the total number of physicians taking care of patients in 23 of our states — are now in government service.

The charge that the AMA has ignored the problem is wholly unwarranted. The long-standing policy position that more physicians are needed has been translated into positive programs.

ACTIVITY: Seventeen years ago, the AMA recognized that many more medical schools

would be needed quickly and began urging Congress to enact a program of federal grants for medical school construction and expansion. A dozen years elapsed, however, before the legislation was enacted. More recently, the AMA has endorsed the use of federal funds for aid in medical school operations.

Seeking to increase the supply of physicians, the AMA has also:

1. Conducted an extensive, continuing, nationwide careers program to attract more young men and women into careers in medicine or in allied health professions or occupations.

2. Inaugurated a loan guarantee program in 1962 to help students, interns and residents finance their education and training.

3. Called for creation of a national commission to properly balance government requirements for physicians against the needs of the public.

4. Participated in the planning and development of the 16 new medical schools which have been built since 1947 and the 10 others that will open by 1971.

5. Appointed a Committee on Health Manpower to study the entire problem of allocation of health resources and to develop constructive, workable solutions.

6. Recently joined with the Association of American Medical Colleges in an urgent program to increase enrollments in the nation's medical schools. The objective is expansion of enrollments to a level permitting all qualified applicants to be admitted.

In addition, the nation's physicians in the last 15 years have contributed almost $68,000,000 to U. S. medical schools, either directly or through the AMA Education and Research Foundation.

Future Medical Meetings

SOCIEDAD MEDICA DE ESTADOS UNIDOS DE NORTE AMERICA Y MEXICO

MEDICAL SOCIETY OF THE UNITED STATES AND MEXICO

The Medical Society of the United States and Mexico will return to the place of its inception, Mazatlan, Sinaloa, for its Sixteenth Reunion, November 6-9, 1968. Dr. Hector Gonzalez Guevara, one of the organization's founders, and Mr. Alfredo (Chato) Patron, Executive Secretary for Mexico, are in charge of the arrangements, the plans now nearing completion.

The scientific program will begin at 9 o'clock each morning, ending at 1:30 p.m. Afternoons will be left open to permit enjoyment of the superb beach and many other attractions of Mazatlan. An organized social function will take place each evening.

Hotel reservations are being handled by Mr. Alberto Escobosa of the ABZ Mazatlan Travel Agency, Paseo Claussen 105, Mazatlan, Sinaloa.

Members will soon be receiving a reservation form from that office. We are now in the process of making arrangements for air transportation from Phoenix and Tucson with Air West and Aeronaves de Mexico. Mazatlan is also served by Mexicana de Aviacion by direct flight from Los Angeles, and there is overnight train service from Nogales.

The weather should be perfect in that beautiful and always hospitable city in November and we anticipate a large turnout. All interested physicians and their wives are cordially invited to attend.

ANNUAL CONFERENCE, AMERICAN SOCIAL HEALTH ASSOCIATION

OCTOBER 27-28, 1968

HOTEL BILTMORE, NEW YORK

AUTOMATED MEDICAL INFORMATION SYSTEM TO BE INSTITUTED IN SOUTHERN ARIZONA

One of the most unique and advanced automated medical information systems ever developed will be instituted over the next 18 months for the San Xavier and Papago Indian Reservations in Southern Arizona, the Department of Health, Education and Welfare and Textron's Bell Aerosystems Company announced recently.

The Arizona Operations of Bell Aerosystems, located in Tucson, will develop the new system under a $160,000 contract. Health Research Inc. of Buffalo, N. Y., which has had extensive experience in the medical and public health fields, will assist Bell in the project. The system is under the direction of the Health Program Systems Center of the Division of Indian Health.

It will include automation of all medical, environmental and sociological files for each of the 8,500 members of the Papago community on a central computer located at Bell Aerosystems Computer Center in Tucson.

Access to the automated files will be possible through remote terminals located at the San Xavier and Santa Rosa medical clinics, and at the Sells hospital and out-patient clinic. The system will provide physicians, public health nurses and environmental specialists with a single data base that is current, complete and immediately accessible regardless of the location at which the patient is being treated. The automated records system will also provide the means of detecting and analyzing health problems on a family and community basis in a timely manner, allowing application of health resources in an optimum manner to prevent or contain the outbreak of communicable diseases.

The program will be under the overall direction of Mr. James E. Miller of the Division of Indian Health, HEW. Dr. A. E. Garratt of the Bell Aerosystems Company, Arizona Operations, is the project director. Dr. Robert K. Ausman, executive director of Health Research, Inc., is associate project director.

The initial system will be experimental in nature but will provide a basic operational information system at the end of 18 months. This system can be expanded to include even greater capabilities in support of hospitalized patients and field health management services.

The Health Program Systems Center of the Division of Indian Health is responsible for administering comprehensive health programs for approximately 400,000 American Indians and Alaskan natives. It is anticipated that the experience and techniques developed for the Papago Reservation will be applicable to other Indian groups, and perhaps will result in the development of completely new concepts in the administration of public health activities for all community groups.

The Arizona Operations of Bell Aerosystems Company was established in Tucson in 1960 and has been involved in the design and implementation of management information and simulation systems for the U. S. Army. It presently has a modern computer center facility at Tucson, and has developed a wide background in the data collection and processing and the computer technology fields.

Health Research, Inc., is a public health research group of the Roswell Park Research Center in Buffalo, New York, and is associated with the New York State Department of Health. HRI is a recognized leader in the development of medical data systems, and in the solution of problems concerned with the delivery of health care to various segments of the population.

Letters to Editor

Dear Dr. Schoen:

In reviewing some recent correspondence, I came across the enclosed letter. It was a response to an inquiry of mine regarding the Office for International Relations in Medicine. The letter from Dr. Hugh Clegg is self-explanatory.

In view of the commendable purposes of this organization, I wondered whether you might wish to use this letter in ARIZONA MEDICINE for the purpose of acquainting your readers with the existence, aims and purposes of this organization.

Very truly yours,
Andre J. Bruwer, M.D.
Radiologist — Tucson Medical Center

Dear Dr. Bruwer:

Thank you very much for your letter about my Office for International Relations in Medicine, which has been officially in existence only since October last year.

Pehhaps the best way to explain its aims and object would be to give you a brief note on how it came about.

The Royal Society of Medicine was asked if it could make a contribution to International Cooperation Year 1965. So the Royal Society of Medicine set up a Committee for this purpose, and serving on it were representatives of the Royal College of Physicians of London, the Royal College of Surgeons of England, the Royal College of Obstetrics and Gynecology, the Ministry of Overseas Development and the British Council. The Committee decided that an attempt should be made to compile a Register, of British/International Relations in Medicine, and I think I am right in saying that they had particularly in mind relationships between British medical institutions of one sort and another with medical schools and hospitals and other centres in the developing countries.

After I had retired from the editorship of the British Medical Journal at the end of 1965, the Committee asked me if I would look into this matter, making a start by sending out questionnaires to medical schools, medical institutions and medical societies in Britain to find out what links they had with similar institutions overseas. It was not until the very end of 1966 that I could see my way clearly to embark on this project, and it was really only in the beginning of 1967 that I was able to draw up questionnaires and send them to the above groups.

By June 1967 I was able to make a report to the R.S.M., and on the basis of this the Society decided to set up an International Relations Office, and appointed me as its first and part-time Director; and I became officially established in the new job in October 1967.

During the past months we have considered various projects related to what I regard is the function of my office, namely to promote international relations in medicine. Two or three promising projects have fallen by the wayside, although it may be possible to retrieve one or two of them yet.

For the time being then, we are concentrating on building a body of information that we hope will be of use in a number of different ways in the future to promote international relations in medicine. We already have, for example, a pretty complete record of the links formed by the British medical schools with the medical schools overseas. We also have a good many facts about the connections with overseas units of some sixty-four speeialist medical societies in Britain. At the moment I am discussing these overseas links with doctors interested in medical care in other countries. What we shall do here is to compile a list of these doctors with special interest in and knowledge of medical care in other countries, and we shall hope to get from them the names of doctors in other countries with similar interests, so that in the future we can put the intending visitor into touch with a foreign colleague. We shall complete this information with a note of the languages spoken or read by the people on the two sides of this relationship.

I might add that very soon we shall begin compiling information about general medical societies in the U.S.A., although I must admit that the prospect terrifies me. But I feel sure that I shall get help from friends in the A.M.A., and I expect indeed that the information will be readily available.

I should be delighted if you would like to make any comments on this scheme of ours, be-

cause I am sure we have a lot to learn yet before we shall be a great deal of use to those seeking information and advice. We really want to be a communications centre, in the first place for British doctors going to different countries, and in return we hope that doctors from other countries coming to England may be able to make use of any help we can offer them.

Very truly yours,
H. A. Clegg, C.B.E., F.R.C.P., Director
Office for International Relations in Medicine
The Royal Society of Medicine
(London)

Editor, Arizona Medicine
4601 North Scottsdale Road, Suite 201
Scottsdale, Arizona 85251

Dear Sir:

The Arizona State Legislature has recently adjourned after a special session in which the first major revision of the Arizona Workmen's Compensation Laws in 23 years was passed. The bill has been signed by the Governor and will become law on January 1, 1969.

The Arizona Medical Association took an interest in this legislation but, to my knowledge, in only ARS 23-908B, charging the Industrial Commission with the responsibility of fixing "a schedule of fees to be charged by physicians attending injured employees, which shall not be exceeded". The legislature amended the last subordinate clause to read: "Which shall be reviewed annually by the Commission". It is obvious that this amendment does not provide specifically for UCR charges for which ArMA lobbied.

During eight years employment by the Industrial Commission of Arizona I have listened more or less sympathetically to many complaints by physicians about aspects of the law and its administration, including fees, free choice of physicians, liberal benefits under the injury law, limited benefits under the occupational disease law, privileged communications, paper work, red tape, treatment by cultists, confusion over liability for nonindustrial conditions, difficulties in rating permanent disability, and intrusion into the doctor-patient relationship.

In spite of the frequency of these complaints by individual members, and occasionally by representatives and committees of the state association, the only official interest showed in the legislative deliberations was in those relating to fees. Personally, I am bitterly disappointed. We will never know if our constructive service-oriented influences brought to bear on the other elements of the legislation might not have stimulated a more favorable reaction on the fee schedule issue.

In January, 1965 I made recommendations to the Professional Committee, which ultimately lead to a directive by the Board of Directors in November, 1966 to the Industrial Relations Committee "to explore the impact of the present Workmen's Compensation and Occupational Disease Laws, and their interpretation by the courts, and administration of these laws by the Industrial Commission on the medical care of the industrially sick and injured". To my knowledge there has been no response to this directive. If there has been, it has not been manifest in any corrective legislation.

In January, 1969 there will be two new public agencies replacing the present Industrial Commission, a new Industrial Commission as an adjudicating body, and a State Workmen's Compensation Insurance Fund operating as a state owned insurance company in competition with private carriers.

The new Commission will adopt a schedule of fees. The physician will be required to report to both the Commission and Insurance Carrier as well as the employer. The remaining details of implementation of the new law which will effect the medical profession will be defined by the governing bodies and management of the two agencies. The establishment of an early liaison with these agencies by the association may offset, in part, our deficiencies in the legislative halls.

Let us labor together.

Sincerely yours,
Walter V. Edwards, M.D.,
Medical Director
The Industrial Commission of Arizona

In Memoriam



Donald L. Green, M.D.
1906-1968

Dr. Donald Green graduated from the University of Arkansas in 1939. He served in the Army Medical Corps from 1941 to 1945. He practiced in Phoenix from 1955 to 1968 at 2145 West Buckeye Road.

I met Dr. Green in 1960 while he was practicing at this location. I observed the manner in which he handled his patients over a period of three years while I was training at Maricopa County General Hospital.

When Dr. Green's patients needed to be hospitalized the majority were sent to Maricopa County General Hospital. You see, he cared for an indigent population and truly denied himself luxuries that most of us enjoy.

Most obituaries end by stating how all of us will mourn his departure — this is true — but for the few who really knew him, the real mourners are the patients he served in Southwest Phoenix.

Stephen E. Flynn, M.D.

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Directors: Blanche C. Lightowler, B.A.

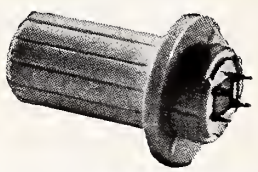
Matthew W. Lightowler

P.O.B. 44, Cortaro, Ariz.

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Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

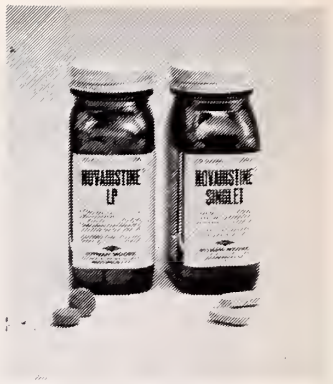
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That's why we make Novahistine® tablets in two different formulations.

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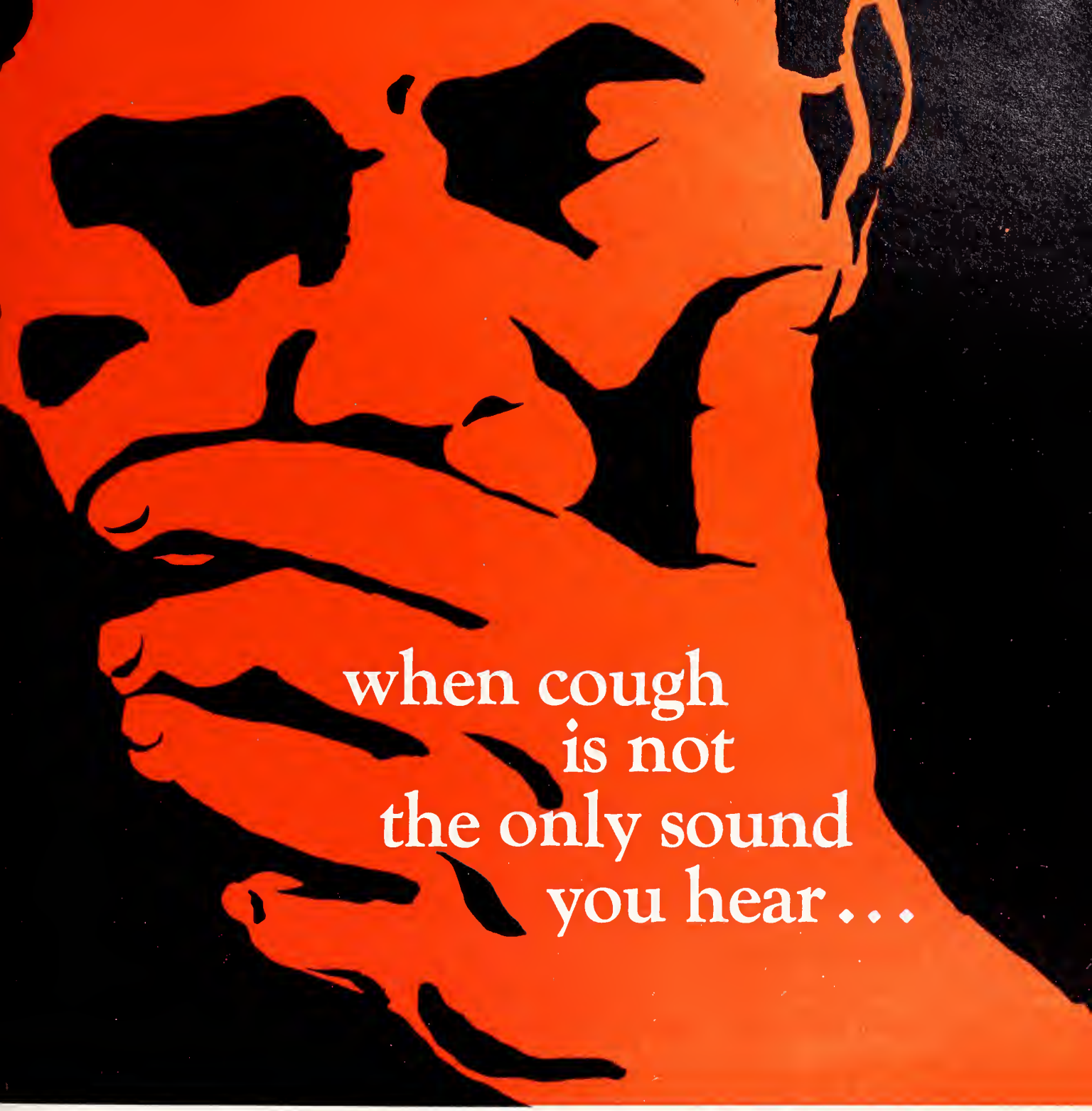
Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.
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With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.
Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.
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. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

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'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
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Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
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enobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
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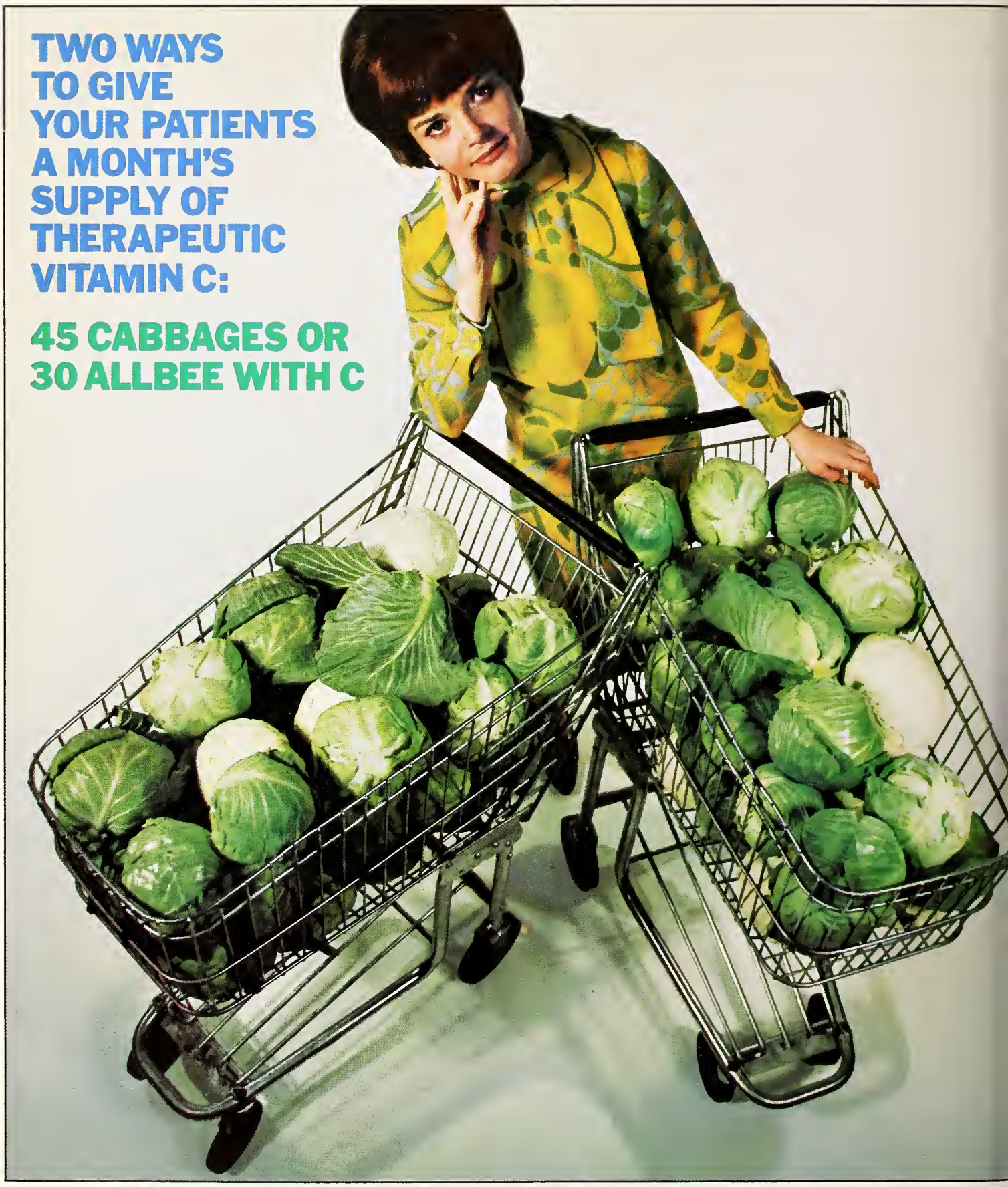
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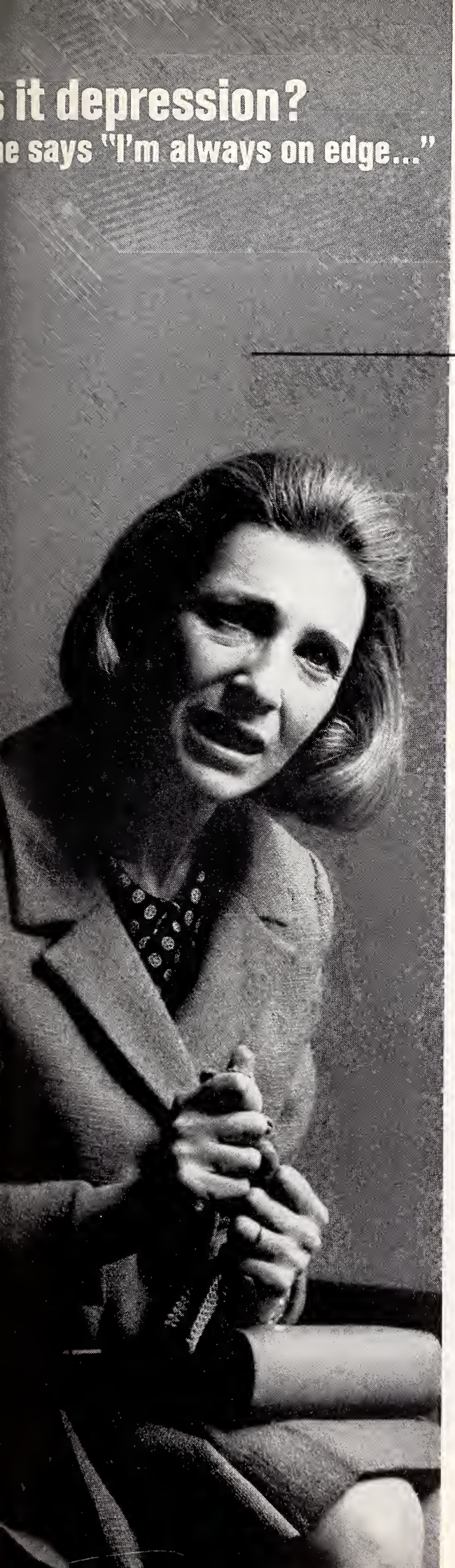
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it depression?
e says "I'm always on edge..."

...but her other symptoms:
depressed mood, insomnia,
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strongly suggest
an underlying depression.

when the diagnosis is depression

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Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

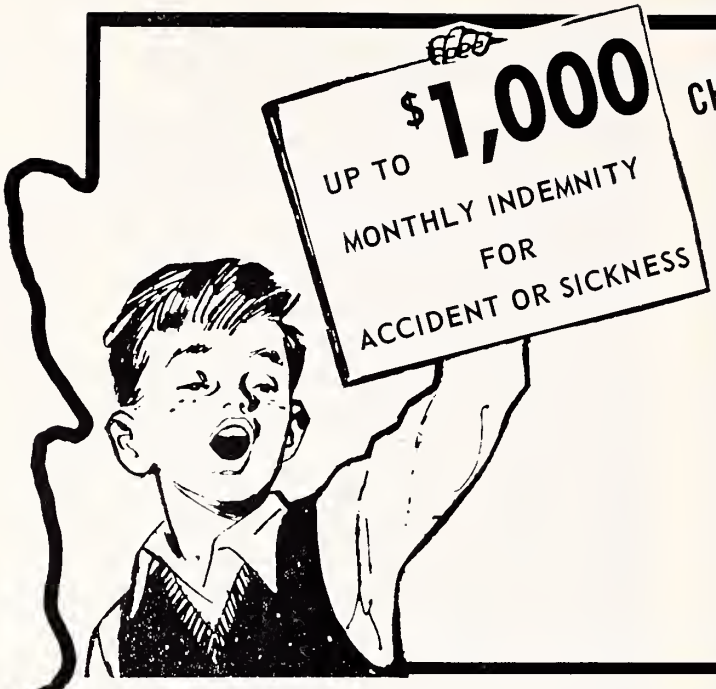
Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

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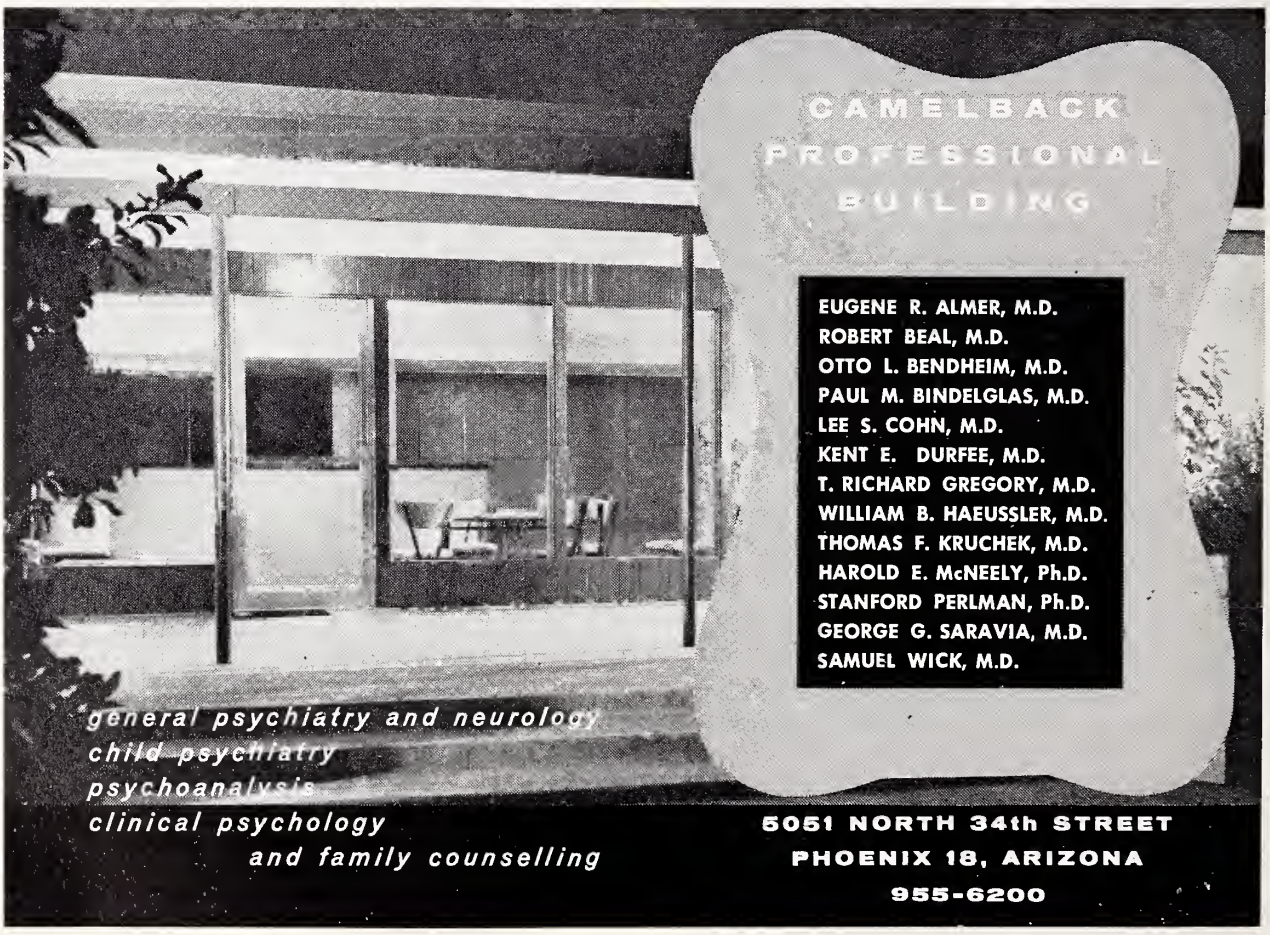
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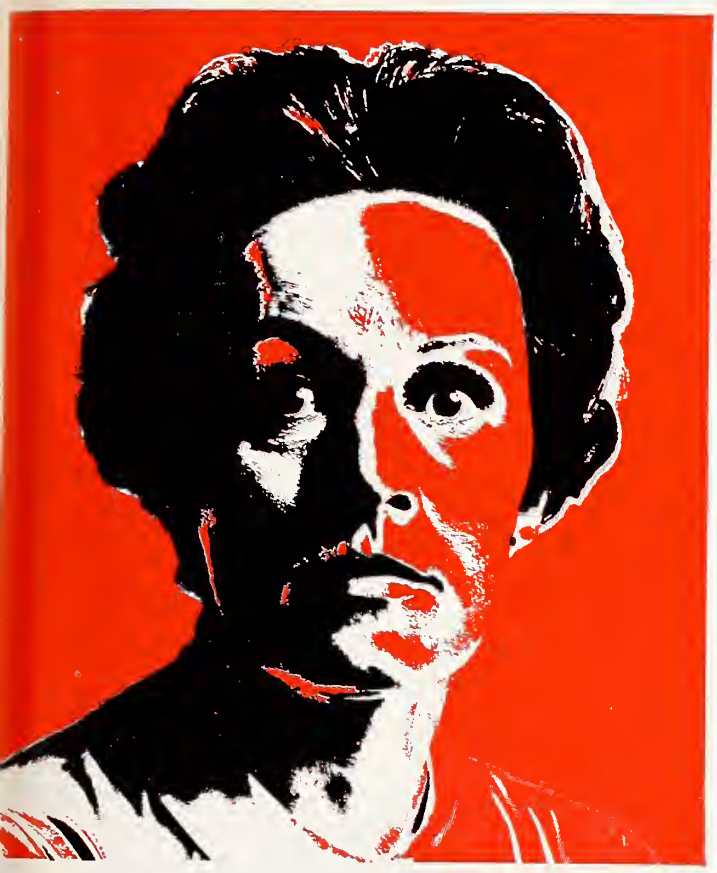
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In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

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Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

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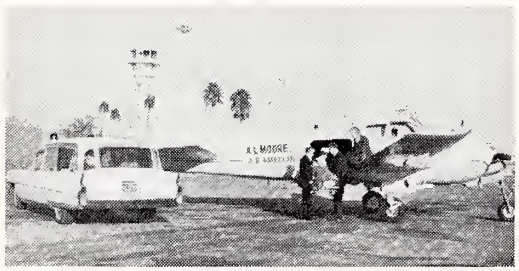
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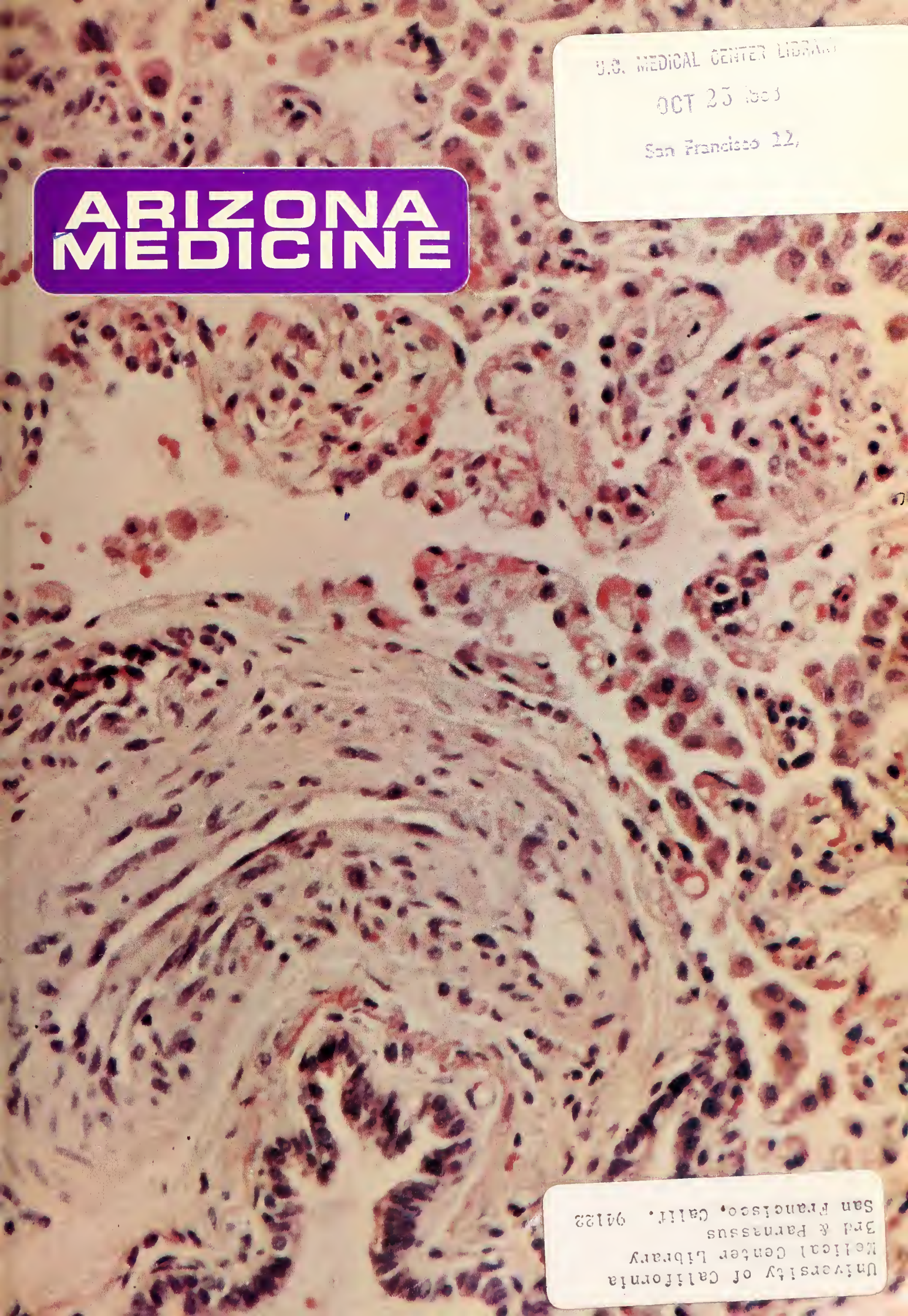
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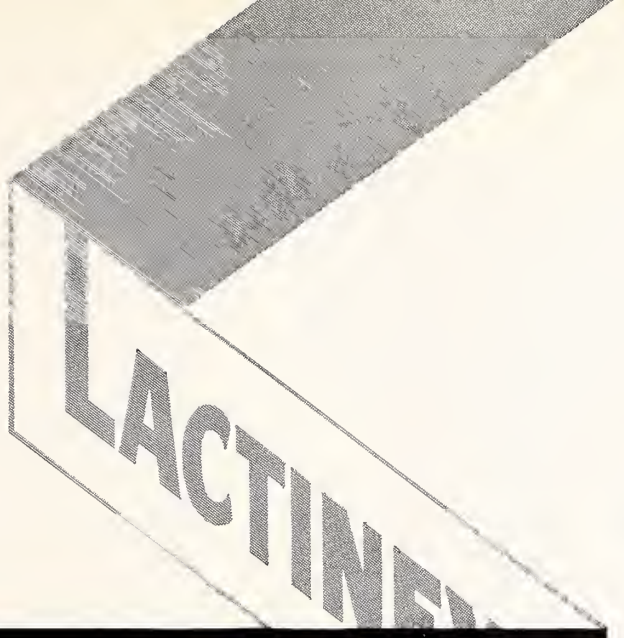
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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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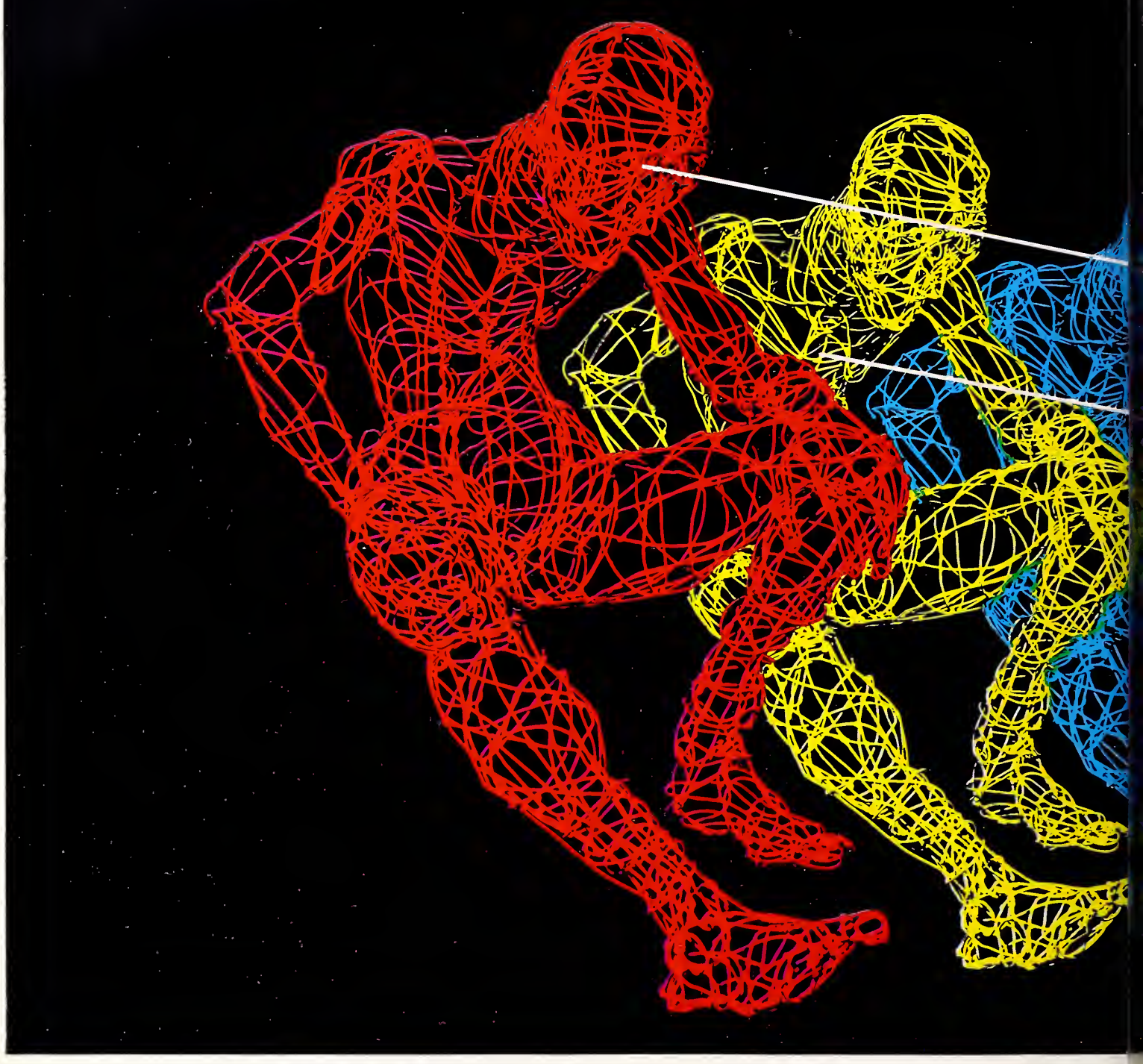
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a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropri e investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequ te vitamin B_{12} therapy may result in hematologic remission but n u- rological progression. Adequate doses of vitamin B_{12} (parenter l, or oral with potent intrinsic factor as in Trinsicon® [hemat c concentrate with intrinsic factor, Lilly]) usually prevent, halt r improve the neurological changes.

As with all preparations containing intrinsic factor, resista e may develop in some cases of pernicious anemia to the poten a- tion of absorption of physiological doses of vitamin B_{12}. If re t- ance occurs, parenteral therapy, or oral therapy with so-ca d massive doses of vitamin B_{12}, may be necessary. No single r i- men fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Peri ic



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

ical and laboratory studies are considered essential and are ommended.

erse Reactions: In rare instances, iron in therapeutic doses duces gastro-intestinal reactions, such as diarrhea or consti- ion. Reducing the dose and administering it with meals will imize these effects.

n extremely rare instances, skin rash suggesting allergy has owed oral administration of liver-stomach material. Instances apparent allergic sensitization have also been reported after l administration of folic acid.

age: One Pulvule twice a day. (Two Pulvules daily produce a ndard response in the average uncomplicated case of perni- us anemia.)

w Supplied: Pulvules Trinsicon® (hematinic concentrate with insic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.
801668

Lilly



"Breathing's a snap again," he said gingerly.

(COMPLIMENTS OF DIMETAPP)

Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done . . . in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A·H·ROBINS

in sinusitis, colds, U.R.I.

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear breathing on one tablet



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Editor's Page

ELECTION

It has long been the policy of ARIZONA MEDICINE to offer to its readers not only the choice of the professional articles which cross its editorial desk, but to print non-professional articles which stimulate evaluation, deliberation, and solution of many problems which face the physicians of the State of Arizona.

Next month, November, we go to the polls to vote in a national election. It is neither the purpose nor the prerogative of ARIZONA MEDICINE to instruct individuals HOW to vote, but it is definitely within our scope of influence to stimulate each individual to VOTE as he pleases.

ARIZONA MEDICINE feels that a rational choice between the candidates for various offices may better be reached by reproduction on page 899 of the remarks made by Wilbur J. Cohen, then Undersecretary of the Department of Health, Education, and Welfare, to a group of social workers in May, 1966. The remarks are titled "Social Policies for the Nineteen Seventies."

This in itself is quite an innocuous title. Other obvious titles will come to mind as the article is read. The article reached ARIZONA MEDICINE from the AMA Field Representative for this area. His basic memorandum to our Central Office is sufficient introduction for the article.

We, too, believe that now is a wonderful time to be alive, to work, to think, to write, to speak, and seek and strive for new and imaginative ways to make a new and better world, but we would first seek solutions to a rapidly inflating dollar; a halt and reduction of rapidly increasing cost of living; a more deliberate and sound fiscal planning; a thoughtfully administered poverty and educational program, and a repeated application of Government OF the people, BY the people, and FOR the people.

Read the article on page 899. Then vote for the candidate of your choice.

BUT VOTE

Reprint — ARIZONA MEDICINE — October 1966

Roland F. Schoen, M.D.
Editor



No one should be cold on a Caribbean cruise

To those with peripheral vascular disease, a balmy ocean breeze can become a limb-chilling wind . . . a stroll on the deck a painful, stop-and-go chore.

Priscoline can help. It dilates peripheral blood vessels, increases blood flow to extremities. Relieves numbness. Makes hands and feet less prone to chill. Makes patients more comfortable. Helps them get around.

Nothing magic about Priscoline. But people with peripheral vascular disease might think so.

See following page for prescribing information.

Priscoline®

(tolazoline)
peripheral vasodilator

CIBA

2/3851

Priscoline®
hydrochloride
(tolazoline hydrochloride)



Indications Spastic peripheral vascular disorders.

Precautions Tolazoline stimulates gastric activity and increases hydrochloric acid content of the stomach; use cautiously in patients with gastritis or peptic ulcer or in those with suspected peptic ulcer. Give cautiously, if at all, to patients with known or suspected coronary artery disease.

Adverse Reactions Occasional: nausea, epigastric discomfort, tachycardia, flushing, slight rise or fall in blood pressure, increased pilomotor activity with tingling or chilliness. Rare: vomiting, diarrhea. Symptoms are generally mild and frequently disappear with continued therapy, regardless of dosage.

Administration and Dosage Careful individualization of dosage is required.

Oral *Tablets:* Usually 25 mg 4 to 6 times daily is sufficient. If necessary, dosage may be increased gradually up to 50 mg 6 times daily.

Lantabs: Generally, 1 Lontab every 12 hours will achieve the same effect as one 25-mg regular tablet every 4 hours (6 times a day). Thus, continuous action throughout the night is achieved without the need for arising to take additional medication.

Parenteral *Subcutaneously, Intramuscularly, or Intravenously:* 10 to 50 mg 4 times daily. Start with low doses, increasing with patient under close observation until optimal dosage (as determined by appearance of flushing) is established. Keeping patient warm will often increase effectiveness of drug.

Supplied *Tablets,* 25 mg (white, scored); bottles of 100 and 1000. *Lantabs,* 80 mg (bright yellow); bottles of 100. *Multiple-dose Vials,* 10 ml, each ml containing 25 mg tolazoline hydrochloride, 0.65% sodium citrate, 0.65% tartaric acid, and 0.5% chlorobutanol as preservative in water; cartons of 1.

Lontabs® (long-acting tablets CIBA)

Consult complete literature before prescribing. 2/3851

CIBA Pharmaceutical Company, Summit, N.J. CIBA

Easy on the Budget... Easy on the Mother

Tablets & Elixir

For Iron Deficiency Anemia

BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

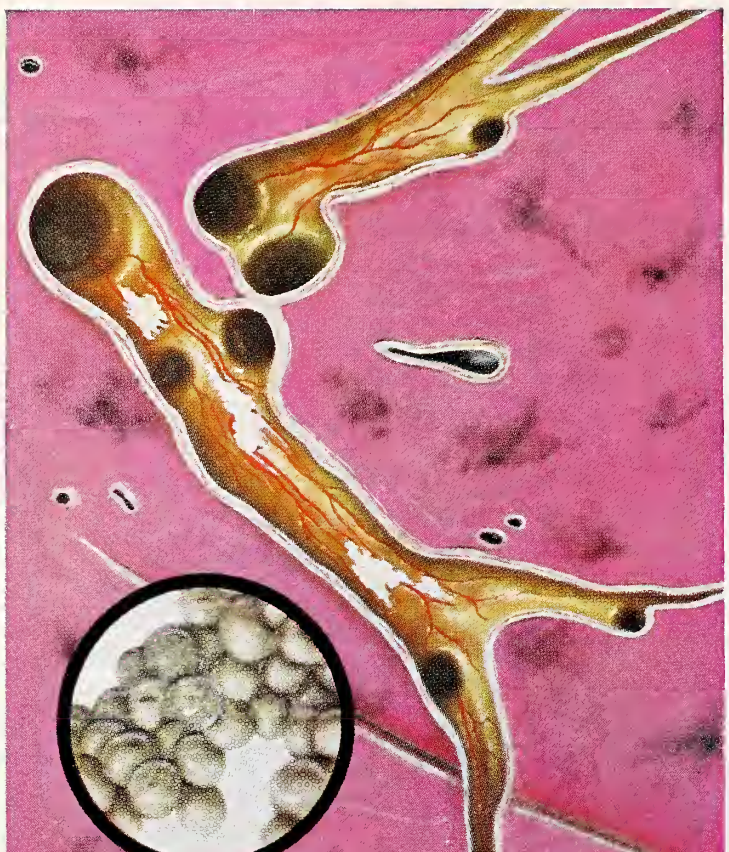
FAMOUS Fergon®
brand of FERROUS GLUCONATE

See next page for prescribing information



You've made it one of your specifics in acute bronchitis

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specifics in acute bronchitis

Your experience has shown that H. influenzae and D. pneumoniae are commonly implicated in acute bronchitis. And DECLOMYCIN is effective against these organisms. Although some strains may resist its action, and other organisms may also be involved, sensitivity testing will prove the usefulness of DECLOMYCIN.

You know, too, that DECLOMYCIN provides rapid, high and prolonged activity levels in both serum and tissue.

Dosage is convenient—300 mg b.i.d. or 150 mg q.i.d.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—Anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

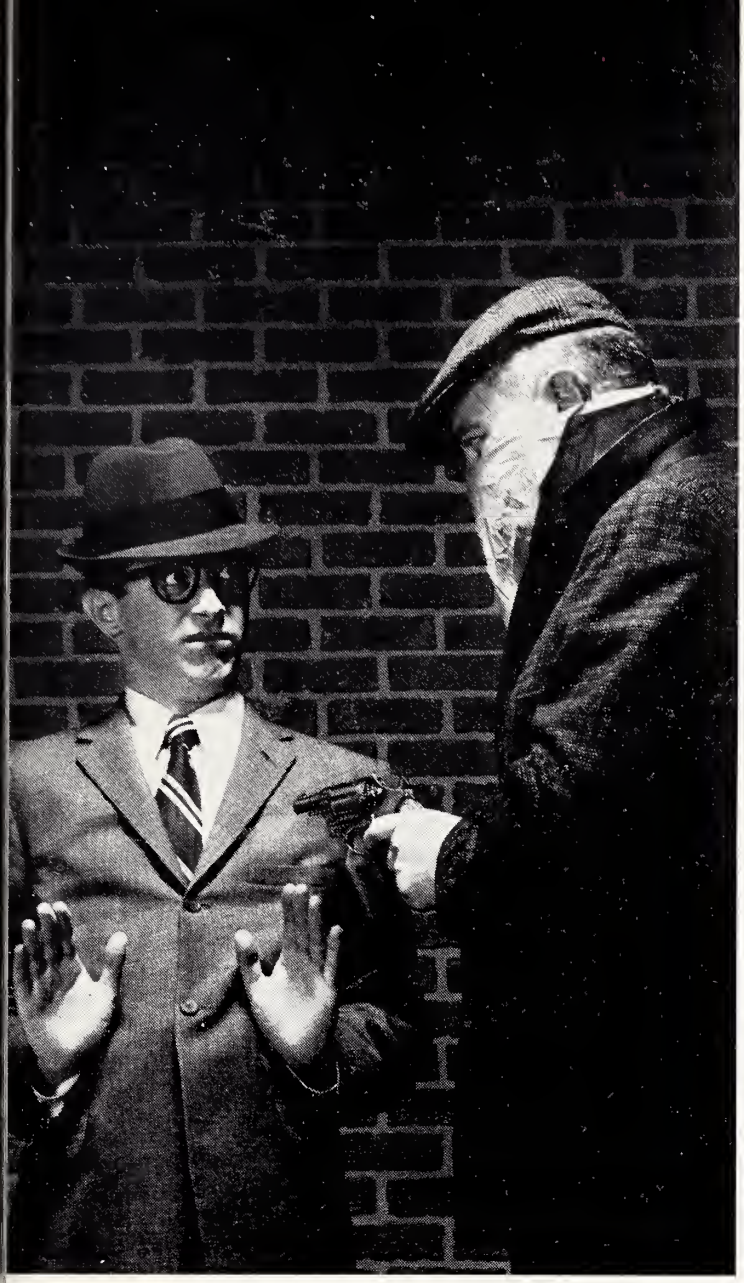
Average Adult Daily Dosage: 150 mg. q.i.d. or 300 mg. b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

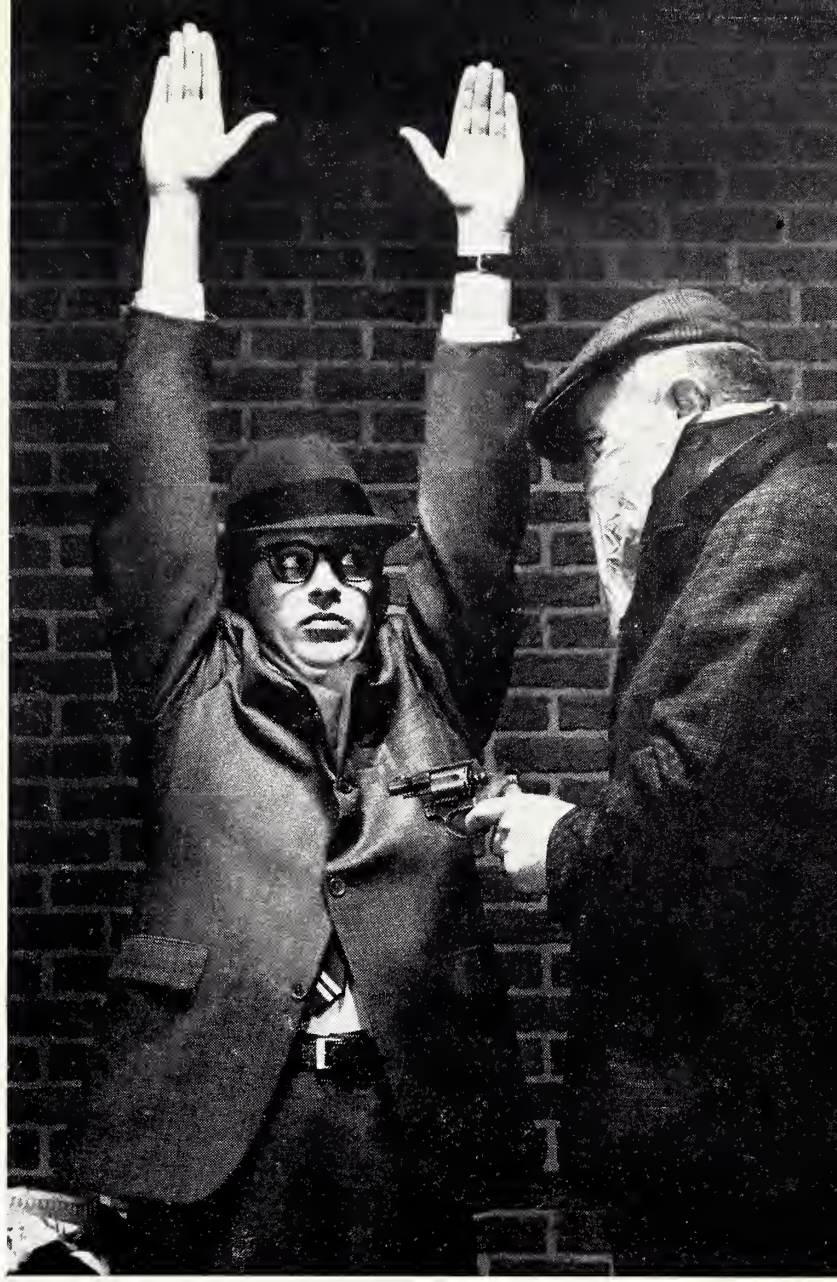
DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg.; **Tablets:** film coated, 300 mg., 150 mg. and 75 mg. of demethylchlortetracycline HCl. 393-8

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle





Picture of a sprained shoulder

treated with Parafon Forte® TABLETS

Paraflex® (chlorzoxazone)* 250 mg.
Tylenol® (acetaminophen) 300 mg.

Parafon Forte helps to relieve pain, restore mobility...stop pain-spasm feedback

Here is why. PARAFON FORTE provides:

nonsalicylate analgesic equal to aspirin for the relief of pain,[1,2] yet unlikely to produce the irritation to the gastric mucosa so often associated with salicylate therapy[3]

and a skeletal muscle relaxant shown to have up to a 6-hour span of action[4]...to retain effectiveness even on continued administration[4]...but not likely to have the central effects of tranquilizing compounds.[5]

Prescribe PARAFON FORTE for effective spasmolysis and analgesia in sprains, strains, myalgias, low back pain, bursitis and other musculoskeletal disorders. Your patients will appreciate the restored comfort and freedom of movement it usually provides.

Contraindications: Sensitivity to either component. ***Precautions:*** Exercise caution in patients with known allergies or history of drug allergies. If a sensitivity reaction or signs or symptoms suggestive of liver dysfunction are observed, the drug should be stopped. ***Adverse Reactions:*** Occasionally, drowsiness, dizziness, lightheadedness, malaise, overstimulation or gastrointestinal disturbances may be noted; rarely, allergic-type skin rashes, petechiae, ecchymoses, angioneurotic edema or anaphylactic reactions. In rare instances, *Paraflex* (chlorzoxazone) may possibly have been associated with gastrointestinal bleeding. While *Paraflex* (chlorzoxazone) and chlorzoxazone-containing products have been suspected as being the cause of hepatic toxicity in approximately eighteen patients, it was not possible to state that the dysfunction was or was not drug induced. ***Usual Adult Dosage:*** Two tablets q.i.d. ***Supplied:*** Scored, light green tablets, imprinted "McNEIL"—bottles of 100.

References: 1. Batterman, R. C., and Grossman, A. J.: Fed. Proc. *14*:316, 1955. 2. Goodman, L. S., and Gilman, A., ed.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Company, 1965, p. 331. 3. Roth, J. L. A., *et al.*: Gastroenterology *44*:146, 1963. 4. Berman, H. H., *et al.*: Dis. Nerv. Syst. *25*:430, 1964. 5. Friend, D. G.: Clin. Pharmacol. Ther. *5*:871, 1964.

*U.S. PATENT NO. 2,895,877

McNEIL

McNEIL LABORATORIES, INC., FORT WASHINGTON, PA.


Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

andearil, oxyphenbutazone:
or brief summary see next page.

Geigy

TA-6006



Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

ACHROMYCIN® WORKS HERE
TETRACYCLINE



ican Map Co., Inc., New York, No. NY 388

See inside fold for product summary.

Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and crythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

ACHROMYCIN® WORKS HERE
TETRACYCLINE

Actually ACHROMYCIN works wherever the infection is due to an organism your lab cultures have shown to be tetracycline-sensitive. No other tetracycline—or analogue—can assure you of quicker or more effective antibiotic action. After all, isn't that what you want for your patient?

ACHROMYCIN was a pioneer in tetracycline therapy. Seventeen years of experience have shown that when the respiratory system, the genitourinary system, or the skin and soft tissue require treatment for infection probably caused by any of a number of sensitive strains, ACHROMYCIN is a wise choice for therapy while awaiting test results.

Available in 31 useful forms to meet your situational needs.

ACHROMYCIN® V
TETRACYCLINE CAPSULES

The cost differential—inconsequential

Lederle
LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

In peptic ulcer: the antacid puzzle



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

Diarrhea

TROCINATE® 400 MG.

BRAND THIPHENAMIL HCL.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

HOBBY HORSE RANCH SCHOOL

A School For Exceptional Children

The Hobby Horse Ranch School is both home and school for a small group of children. It welcomes the child who is mentally retarded and physically handicapped as well as the backward child who suffers no physical handicap.

The Hobby Horse Ranch School is a branch of Fairview School in Fishkill, New York which was established in 1936.

Directors: Blanche C. Lightowler, B.A.

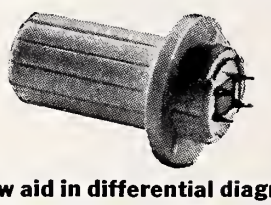
Matthew W. Lightowler

P.O.B. 44, Cortaro, Ariz.

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST

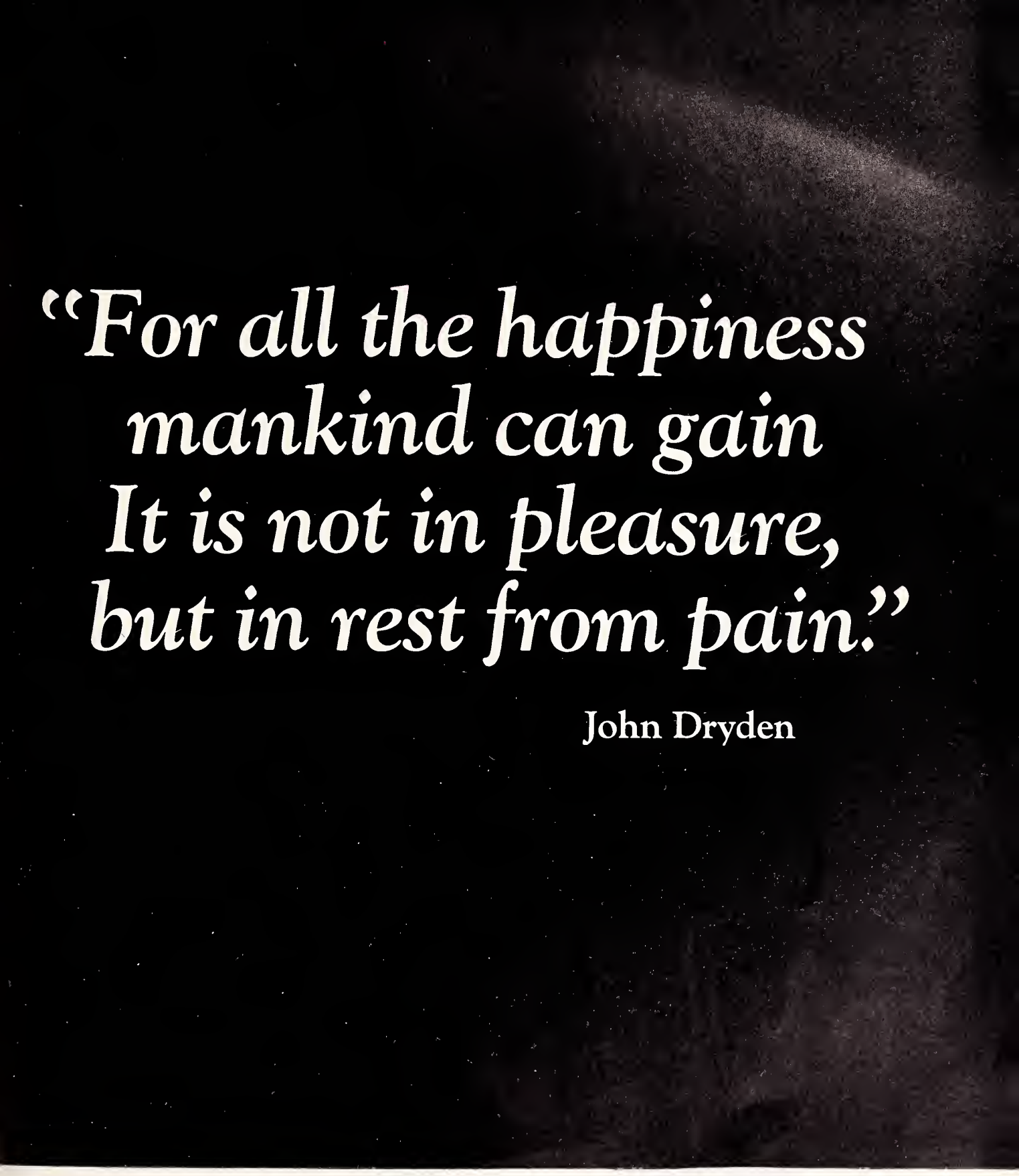
(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8



mpirin'® Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Asplrin gr. 3 1/2, Caffeine gr. 1/2.

gives your patient rest from pain

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



"Upper respiratory infection! I thought everything was a 'virus' these days?"

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® in two different tablet formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

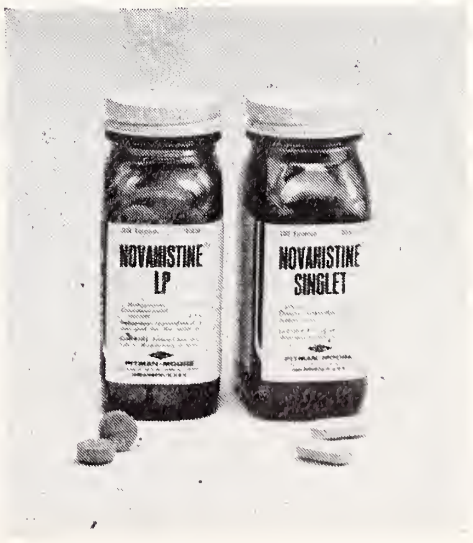
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Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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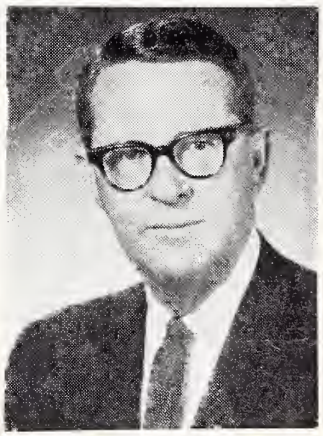
DESQUAMATIVE INTERSTITIAL PNEUMONIA



CECIL C. VAUGHN, M.D., F.A.C.S.

A DEFINABLE PULMONARY LESION OF SIGNIFICANT DIAGNOSTIC AND THERAPEUTIC INTEREST. THIS PAPER PRESENTS A THOROUGH APPRAISAL OF A POORLY UNDERSTOOD CLINICAL ENTITY.

From the Division of Thoracic and Cardiovascular Surgery, Department of Surgery, University of Utah College of Medicine and The Latter-Day Saints Hospital, Salt Lake City, Utah.



PRESTON R. CUTLER, M.D., F.A.C.S., F.C.C.P.

Desquamative interstitial pneumonia (DIP) is a distinct clinical entity characterized by ventilatory insufficiency, a definite radiographic pattern, and uniform histologic appearance. Liebow[3] in 1965 originally described this syndrome and presented the clinical characteristics in 18 collected cases. Gaensler[1] et al., described an additional 12 cases. It is the purpose of this communication to present three cases of desquamative interstitial pneumonia, all proved by open pulmonary biopsy, bringing the total number of reported cases to 35.

Case #1:

C. E., a 64-year-old white male was admitted to the Thoracic and Cardiovascular Division of the Latter-Day Saints Hospital, Salt Lake City, Utah, in August 1967 with complaints of dyspnea, fatigue, bilateral pleuritic chest pain, hemoptysis and cough. The patient smoked one to two packages of cigarettes daily for approximately thirty years. There was no history of weight loss or tuberculosis. Physical examination showed a chronically ill emphysematous male with fine crackling rales heard diffusely over both hemithoraces. On slight exertion there was

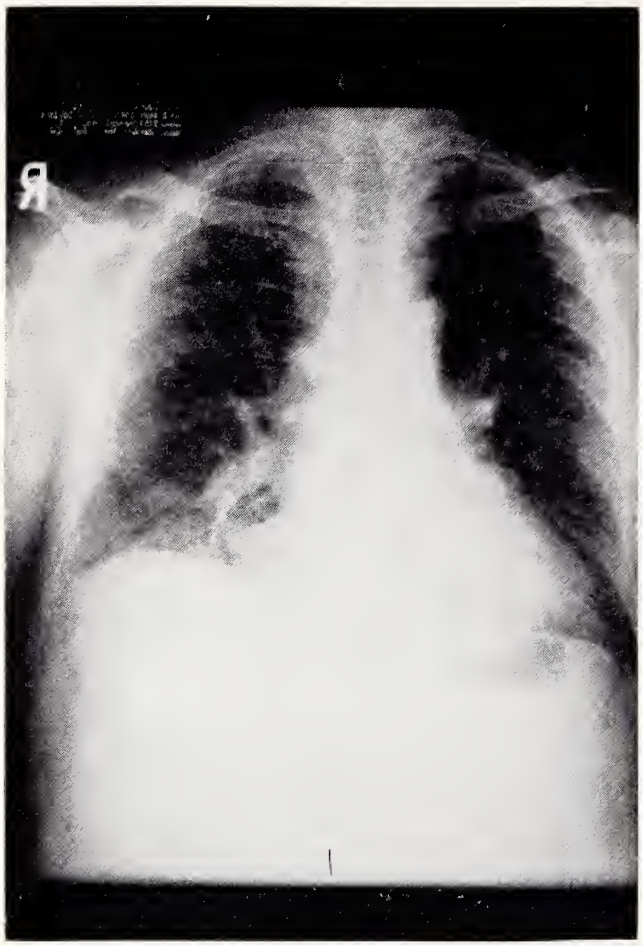


Figure 1 — Patient C. E., posterior anterior X-ray of the chest showing bilateral interstitial involvement with fibronodular streaking from the hilum inferiorly. A honeycombed appearance is seen in the lateral lung fields extending superiorly as far as the second anterior interspace. No evidence of cavitation is seen.

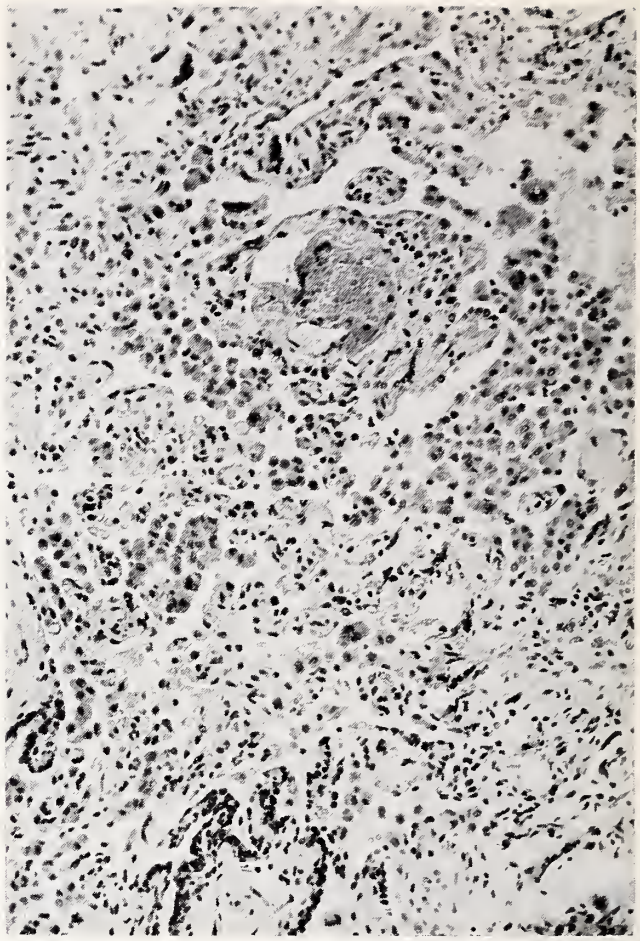


Figure 2 — Patient C. E., photo-micrograph (10X) shows alveolar septal cells filling a distal air sac. These cells have a fine granular eosinophilic cytoplasm and have a positive reaction with the PAS stain. Also seen in these sections were nodular areas of lymphocytes and occasional multi-nucleated giant cells.

intense cyanosis and air hunger requiring oxygen therapy. No pulmonary osteoarthropathy was noted. Laboratory data included hemoglobin 18.7 gms%, hematocrit 58%, WBC 9300, with 89% polymorphonucleocytes. The eosinophil count was 1%. Urinalysis, routine skin tests, liver bracket, BUN, fasting blood sugar, cholesterol, cardiac enzymes, calcium, phosphorus, serum proteins and VDRL were normal. Sputum smear was negative for eosinophils, acid fast bacilli, and malignant cells. Culture of bronchial washings showed alpha hemolytic streptococcus, Diplococcus pneumoniae, and non-hemolytic streptococcus. The sputum cytology was negative for malignant cells. The chest X-ray is demonstrated in Figure 1. Electrocardiogram showed premature ventricular contractions with ST segment depression in Leads II, III, and AVF. The T wave was inverted in Leads III and AVF. The EKG was diagnosed as showing possible posterolateral myocardial ischemia, Bronchoscopy and scalene node biopsy were non-diagnostic. On Sept. 6, 1967, through a small anterolateral thoracotomy, wedge resection of the right lower lobe was carried out. This was accomplished by wedge resection. The photo-micrographs of this biopsy are shown in Figure 2 and Figure 3. The patient recovered nicely from thoracotomy and biopsy. With the diagnosis of desquamative interstitial pneumonia, he was given Prednisone 15 mg. q.i.d., and Declomycin, 300 mg. q.i.d. He had marked symptomatic improvement and was discharged on his tenth postoperative day. He developed recurrent symptoms of dyspnea and cyanosis two months later despite continued steroid therapy. These respiratory symptoms, plus urinary retention with E. coli bacteremia, prompted readmission on January 5, 1968. The patient died on January 13, 1968, of progressive cardiac failure with severe alveolar capillary

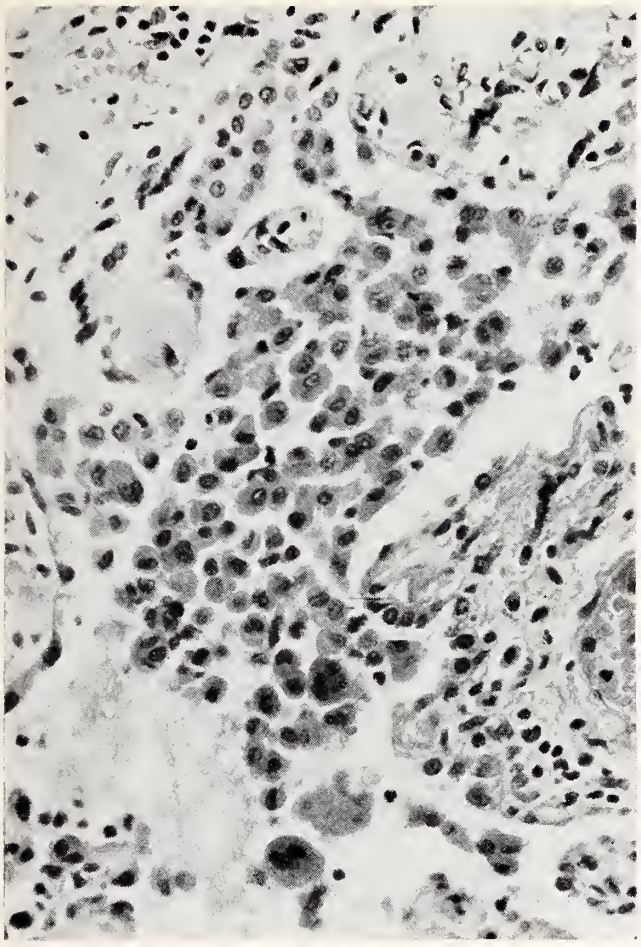


Figure 3 — Patient C. E., photo-micrograph (40X) showing alveolar septal cells filling distal air sac. The large cells have a finely granular eosinophilic cytoplasm with a negative stain for iron.



Figure 4 — Patient R. N., posterior-anterior X-ray of the chest showing hazy densities of the right lower lung field with some fibronodular streaking about the hilum with sparing of the left costophrenic angle and superior lung fields bilaterally.

block. Post-mortem examination disclosed gross "honeycombing" of the lungs. The histologic lung sections showed interstitial fibrosis compatible with a diagnosis of Hamman-Rich Syndrome. Comparison with the previous lung sections indicated a progression of the disease from a diagnostic picture of D.I.P. to one characterized by interstitial fibrosis. A stenotic bicuspid aortic valve and ascending urinary tract infection were also present.

Case #2:

R. N., 51-year-old white male was admitted to the Thoracic and Cardiovascular Division of the Latter-Day Saints Hospital, Salt Lake City, Utah, on July 3, 1967, with a chief complaint of pleuritic pain. He noted that his fingers have been clubbed for several years.

Physical examination showed mild pectus excavatum and clubbing of the fingers. Cardiopulmonary examination was normal. Laboratory data included hemoglobin 15.1 gms%, hematocrit 47%, WBC 8100, with 90% polymorphonucleocytes. The eosinophils were not increased. The urinalysis, cardiac enzymes, total serum protein, routine skin tests, bronchial washings for cytology and culture were all within normal limits. Electrocardiogram showed ST segment elevation in Leads II, III, and AVF, suggestive of posterior myocardial infarction, old. Chest X-rays are demonstrated in Figures 4 and 5. Bronchoscopy on July 8, 1967, showed mild diffuse tracheobronchitis with no evidence of tumor. Scalene node biopsy was non-diagnostic. Open pulmonary biopsy (wedge resection — right lower lobe) was done on July 13, 1967. The lung was described as "meaty" in consistency with enlargement of the subpleural lymphatics. Photomicrographs of this biopsy specimen are reproduced in Figures 6 and 7. The diagnosis of desquamative interstitial pneumonia was made



Figure 5 — Patient R. N., right lateral view of the chest showing right basilar involvement.

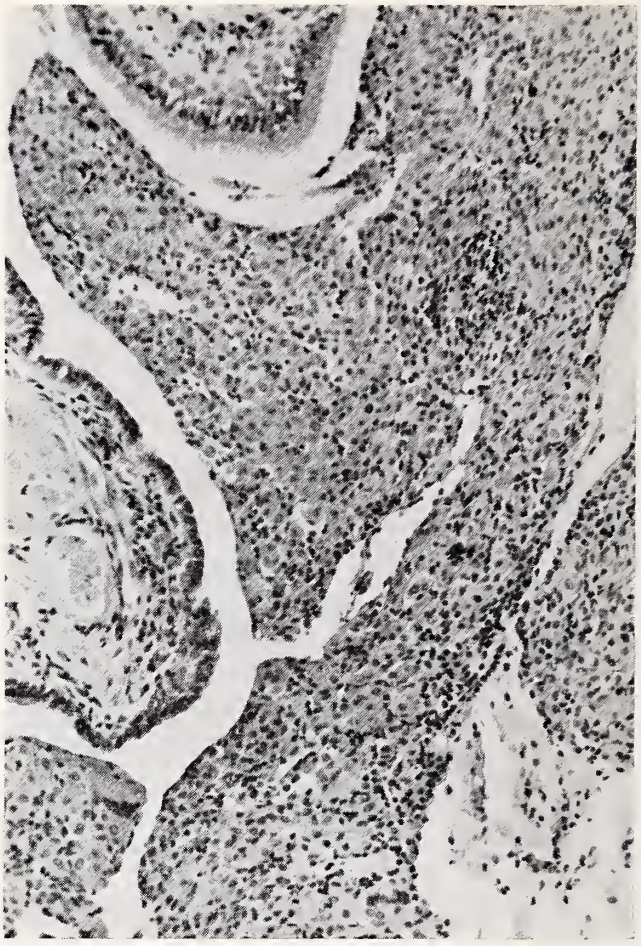


Figure 6 — Patient R. N., photo-micrograph (10X) showing alveolar septal thickening with proliferation of alveolar septal cells. Some multi-nucleated giant cells not of the Langhans type are seen. Special stains showed no iron pigment in the pneumocytes, PAS stain was strongly positive.

and the patient was accordingly started on Prednisone, 20 mg. q.i.d., and Achromycin, 250 mg. q.i.d., with adequate symptomatic response. He was discharged on July 19, 1967. This patient was last seen on August 15, 1967, with no respiratory complaints of any kind. He is being continued on Prednisone therapy and has minimal respiratory symptoms.

Case #3:

S. L., a 47-year-old white male was admitted to the Thoracic and Cardiovascular Division of the Latter-Day Saints Hospital, Salt Lake City, Utah, on January 3, 1967, with chief complaints of exertional dyspnea and increasing fatigability over a twenty-year period. The patient was a heavy smoker with a chronic cough, occasionally productive of thick sputum. There was no history of chills, fever, hemoptysis, or night sweats. In August of 1966 he sustained rib fractures and a traumatic hemothorax in an automobile crash. At that time he was told that he had an infiltrate in his lungs but did nothing about this in the way of follow-up. Physical examination showed a cyanotic white male with increased AP diameter of the chest, mild pectus excavatum and bilateral basilar moist rales. There was no pulmonary osteoarthropathy.

Laboratory data included hemoglobin 17.9 gms.%, hematocrit 50%, WBC 9200, with 75% polymorphonucleocytes. The eosinophil count was not increased. Acid fast stains of his sputum were negative. The chest X-ray is demonstrated in Figure 8. Open pulmonary biopsy, (wedge resection of the lingula) was done on January 4, 1967. A photo-micrograph of this biopsy is demonstrated in Figure 9 and Figure 10. With the diagnosis of desquamative interstitial pneumonia, the patient was started on steroid therapy with an adequate response. On September 25, 1967, the following pulmonary function studies were

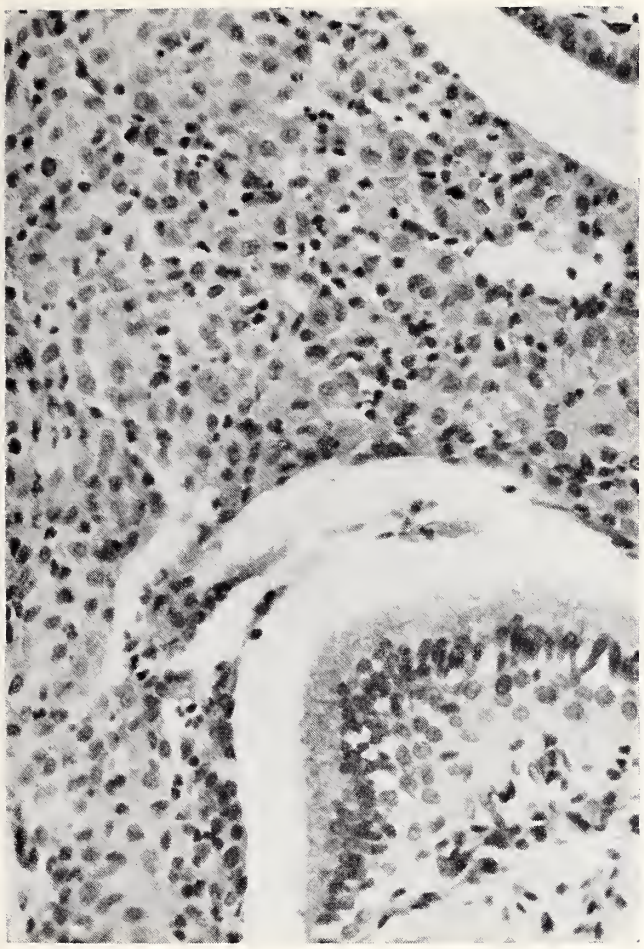


Figure 7 — Patient R. N., photo-micrograph (40X) of same slide as Figure 6. The large sheet of desquamated alveolar septal cells are noted.

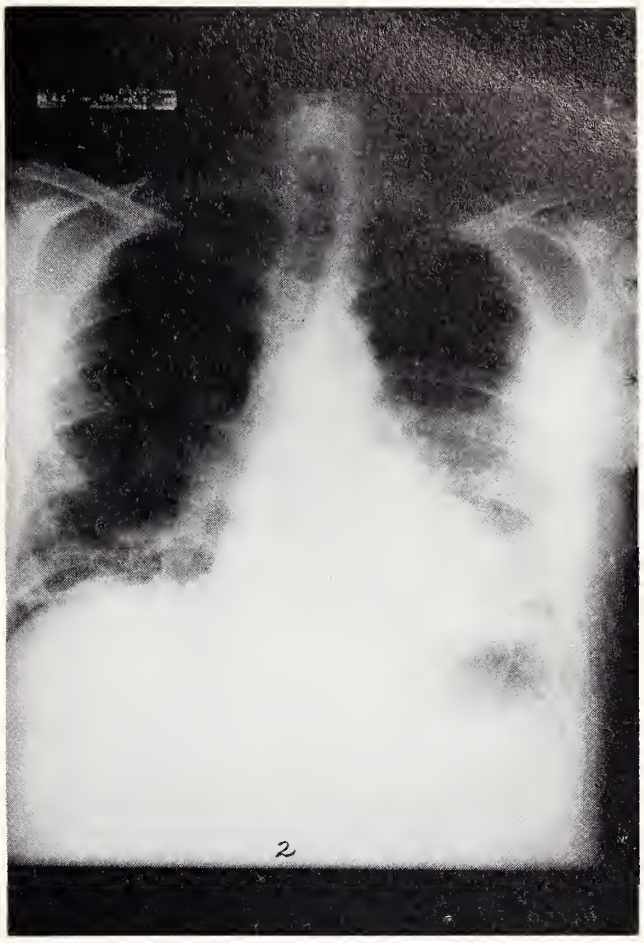


Figure 8 — Patient S. L., posterior anterior X-ray of the chest shows bilateral interstitial involvement of the lungs, more marked on the left side. The hazy, soft infiltrate beginning at the hilum and extending inferiorly is noted. The upper lung fields are spared.

obtained: Vital capacity 3700 cc. (83%), 1 second 2.65 liters, 2 seconds 3.15 liters, 3 seconds 3.35 liters. Maximal breathing capacity was 105 liters per minute with a predicted normal of 120 to 130 liters per minute. The midexpiratory flow rate was 360 liters per minute. He has continued to do well on steroid maintenance.

Clinical Discussion:

The etiology of desquamative interstitial pneumonia is unknown. A viral origin has been hypothesized because of the occasional finding of intracytoplasmic inclusion bodies. This syndrome is probably not one of hypersensitivity. Males and females are affected equally. Ages of our patients were 64, 47, and 51 years of age. In Liebow's cases[3] 12 of 18 cases were 35 to 55 years of age. One was less than 25 years of age. Three were older than 60 years. Schneider[4] recently reported desquamative interstitial pneumonia in a 4-year-old female. There has been no specific environmental hazard or allergen in any reported cases, including our own.

The two most prominent symptoms are dyspnea and pleuritic chest pain; one of our patients (C. E.) had hemoptysis. In one patient the onset of pain was acute; in the other two the complaints were present three and twenty years before admission, respectively. Two of the three patients had mild pectus excavatum. Lung auscultatory findings varied from fine diffuse moist rales to normal findings. Clubbing was not uniformly present. All three patients developed exertional cyanosis. Case #1 demonstrated acute hypoexmia on slight exertion. All of the patients appeared chronically ill with a cough productive of mucoid sputum in moderate amounts.

Post-mortem examination in one of our patients (C.E.) disclosed gross honeycombing of the lungs and severe interstitial fibrosis. One could reasonably conclude that these changes

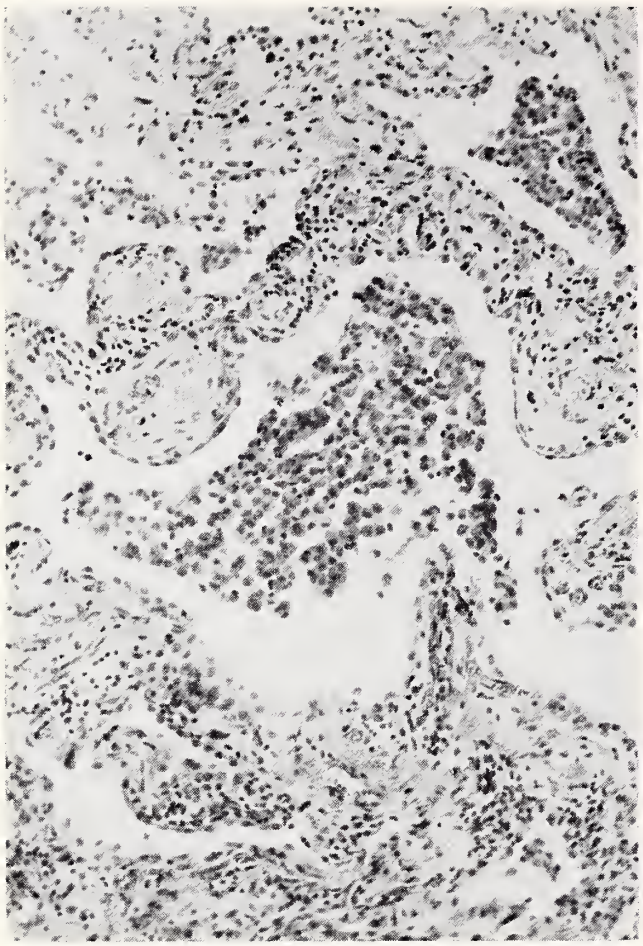


Figure 9 — Patient S. L., photo-micrograph (10X) an alveolar space filled with large cells with an eosinophilic cytoplasm and uniform ovonuclei is demonstrated. Proliferation of the alveolar septal cells is noted. Multinucleated giant cells can be seen. The alveolar septae are fibrotic. PAS stain is positive, the cells have a negative when stained for iron.

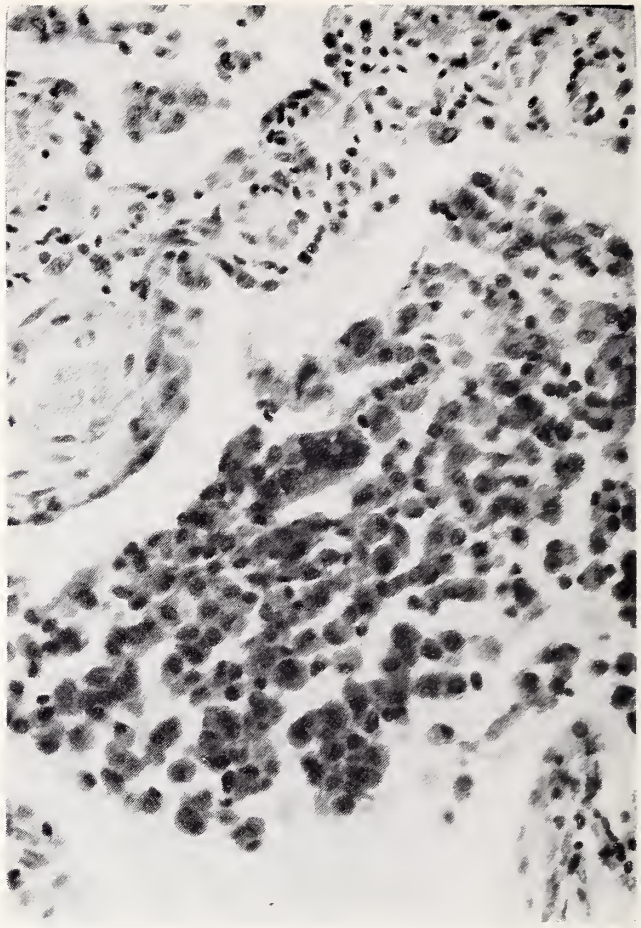


Figure 10 — Patient S. L., photo-micrograph (40X) view showing large multi-nucleated giant cell in the midst of desquamated alveolar granular pneumocytes. The uniform oval nuclei are noted and a finely granulated eosinophilic cytoplasm.

are secondary to a virulent form of desquamative interstitial pneumonia; or more likely that there can be considerable overlapping of the histopathology of various interstitial pneumonias.

Representative chest X-rays are demonstrated in the case presentations. Typical findings include ground glass opacification of the lower lung fields with fibronodular inferior streaking from the hilum with sparing of the costophrenic angles. These original lesions were described by Liebow[3] as being characteristic of desquamative interstitial pneumonia. They are certainly not diagnostic and as more cases of this syndrome are seen varying pictures of the radiographic pattern will be noted. The X-ray picture cannot be correlated clinically with the severity of symptoms.

Alterations in pulmonary function tests, described in previous publications, assume a familiar pattern.[1, 3] The vital capacity is usually slightly reduced initially but the restriction is not marked in the absence of pleural thickening, surgery, or ateletasis. The maximum breathing capacity was 92% of normal in tested cases. Residual volume has not been increased. Hyperventilation during standard exercise was noted. Arterial oxygen desaturation with markedly increased alveolar-arterial oxygen difference is usually present. Cardiac catheterization data in previous reports[1,3] have shown no consistent abnormalities other than arterial oxygen desaturation. Carbon monoxide diffusion capacity is usually diminished. Essentially the most common features are arterial oxygen desaturation, elevated alveolar arterial oxygen gradient, and diminished carbon monoxide diffusion capacity with low pulmonary compliance. Arterial PCO_2 is less than 40, indicating hyperventilation. The hematocrit and hemoglobin determinations are usually about 15 gms% and 50%, respectively, re-

flecting the secondary polycythemia.

Grossly the lungs are stiff and nodular with a yellowish gray honeycombed appearance. Microscopically the distal air sacs are filled with large alveolar cells (granular pneumocytes). There is evidence of alveolar septal thickening with proliferation of lining alveolar cells. The cells lining the alveolar spaces consist of 1: membranous pneumocytes (of Macklin); these are flat lining cells. 2: Granular pneumocytes (septal cells); these frequently contain cytoplasmic lamellated bodies. 3: Macrocytic pneumocytes (alveolar histiocytes). The life of the alveolar cells is from 53 to 57 days[3]. The stimulus for the intense cytorrhea in DIP is unknown. The changes are similar to those of lesions in rats produced by the Grey lung virus.

The differential diagnosis includes pneumoconiosis, lymphangitic tumor spread, infectious pulmonary disease, other forms of interstitial pneumonia such as the Hamman-Rich syndrome, primary pulmonary hemosiderosis, eosinophilic granuloma of the lung and alveolar proteinosis.

In other forms of interstitial pneumonia there is frequently found hyaline membranes, interalveolar fibrosis and tissue necrosis. These findings are lacking in desquamative interstitial pneumonia. The total lung capacity and residual lung volume are usually normal in DIP and decreased in other interstitial pneumonias. The steroid response in DIP is good as compared to other forms of interstitial pneumonia.

Idiopathic pulmonary hemosiderosis is characterized by proliferation of alveolar cells rich in hemosiderin with positive Periodic Acid Schiff stain. Alveolar hemorrhage is common (rare in DIP); alveolar hemorrhage and hemosiderosis are occasionally seen with glomerulonephritis (Goodpasture syndrome).

Alveolar protenosis, like DIP, shows proliferation of granular pneumocytes, but in the former there is massive change in the lining cells with necrosis which is not present in DIP. This may reflect the fundamental defect in alveolar proteinosis of failure of the mechanism to remove dead cells. Lesions of alveolar proteinosis usually show hilar involvement.

Eosinophilic granuloma (Histiocytosis X) is characterized by interstitial rather than alveolar proliferation. Mitoses are common in the acute form (Letterer-Sewé disease). Honeycombing and cavitation are common. Spontaneous pneumothorax is sixteen times as common in Histiocytosis X as in the general population; this complication has been observed infrequently in patients with desquamative interstitial pneumonia.

Despite the above facts the only postive diagnostic tool in DIP is pulmonary biopsy.

Treatment should be started as soon as possible after making the diagnosis. Steroid administration forms a backbone of therapy but should be supplemented by oxygen, antibiotics, digitalis, and attention to tracheobronchial toilet with intermittent positive pressure breathing and general supportive measures as required. The initial dose of Prednisone may be from 40 to 80 mg. per day, reduced over a three to four week period of 20 to 25 mg. per day, depending on patient response. Cessation of steroid therapy in DIP often leads to exacerbation of the respiratory symptoms[3].

Summary:

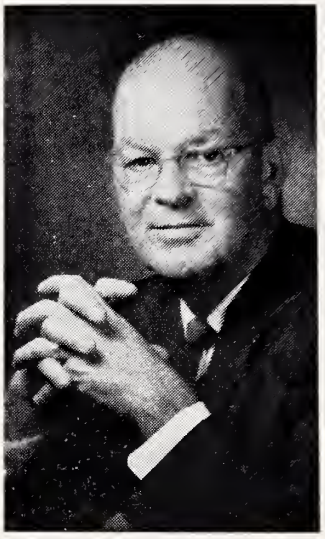
Three cases of desquamative interstitial pneumonia are presented. Diagnosis was made by open thoracotomy and lung biopsy. The microscopic uniformity of lesions includes extensive proliferation and desquamation of alveolar granular pneumocytes devoid of iron. Hilar membranes, necrosis, exudate and alveolar hemorrhage are usually absent. Slight septal thickening and peripheral lymphoid follicles are characteristic. The chest X-ray is typical but not specific. Pulmonary function tests show arterial oxygen desaturation, elevated alveolar arterial oxygen difference (alveolar capillary block), diminished carbon monoxide diffusion capacity, and a decreased pulmonary compliance. The differential diagnosis is discussed. A positive diagnosis can be made only by pulmonary biopsy. Treatment with steroids offers a good chance for symptomatic improvement although the natural history of this disease is unknown; the possible lethal potential must be recognized. DIP should be considered a distinct syndrome with the realization that there may be considerable overlap of the histopathologic pictures of the various interstitial pneumonias.

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SIMPLE MASTECTOMY AND IMMEDIATE REPLACEMENT PROSTHESIS



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Mastectomy, whether "simple" or "radical," poses a grave threat to women both physically and psychically, regardless of age or social position, as amply attested by a medical literature too numerous to recount[1, 2, 4, 5, 7, 10] as well as by the experience of the surgeon called upon to perform the operation. Renneker[7] states that a woman's breasts have consciously or subconsciously a dual meaning. They are at once her symbol of sex and her symbol of motherhood. To threaten the breast is to shake the very core of her feminine orientation. Society for the past few generations, with its vast pictoral news media, has emphasized the role of the female breast as epitomizing the obvious ultimate in femininity, sex and the reproductive process (which is less obvious, but implied), to such a point that women have been known to procrastinate on or refuse surgical approach to even premalignant and patent malignant diseases of the breast.

That this is a serious problem in detection and treatment of breast lesions is amply proven in that 25,139 women died of cancer of the breast in 1963 in the United States[6] and an estimated 50,000 new cancer cases were discovered.[5]

These statistics do not take into account the tremendous numbers of breast biopsies which must have been done during the same year which proved to be "benign" fibrocystic disease of the breast! When one considers that approximately 3.49 "benign" biopsies are found in a large general hospital for every single malignant biopsy of the breast,[12] the above 50,000 new cancer cases could represent well over 174,500 operations performed in that year!

Fibrocystic disease of the breast is considered to be a "benign" condition. However Davis[3] found "the incidence of breast cancer in women with fibrocystic disease to be 2.64 times greater than in women in general." Therefore, fibrocystic disease must be considered a premalignant disease of the breast and should be watched closely and periodically to give the patient the greatest protection from her disease. But even with close observation of the patient and regardless of the routine established by the individual surgeon for follow-up of these patients, it is impossible to handle them with certainty because of the very nature of the disease and its widespread dissemination throughout the breast when present. Consequently repeated biopsies of the fibrocystic breast is the ultimate outcome. And this is not proof positive since how frequently has the surgeon biopsied a "benign" lesion of the breast only to see a carcinoma develop within a few centimeters of his previous biopsy! The conscientious surgeon is therefore forced to the conclusion that all lesions must be biopsied if one is to be certain. This the patient will not accept because of the many incisions required and the disfigurement which will inevitably result. "Simple" mastectomy is the ultimate biopsy method as inferred by Pangman[5] who states that "with multiple lesions in the breast, single or even repeated biopsies do not afford accurate diagnosis since several types of pathological processes may be present. The entire gland should therefore be removed and examined." The patient rebels at the thought, as well as the surgeon.

Yet today, the surgeon has at hand a simple surgical procedure which will dispel the patient's anxieties and fears of disfigurement and the psychological trauma that goes with it, namely, Simple Mastectomy With Immediate Replacement Prosthesis. This operation has been practical since Cronin introduced his preformed silastic mammary prosthesis before the Third International Congress of Plastic Surgery in 1963.[9] Since that year, many articles have appeared attesting to its use in both augmentation and replacement mammoplasties, but we are only concerned with the latter in this article. Prior to 1963, classical reconstruction of the breast was by pedicle grafts from the abdomen, the back, or the other breast, which in themselves were disfiguring and frequently unsuccessful because of necrosis of the graft or because of later shrinkage and absorption of the grafted fat pads. Immediately prior to the introduction of the Cronin prosthesis, reconstruction of the breast was accomplished by prosthesis of Etheron, Ivalon and Silastic sponge. These had many disadvantages such as shrinkage, an unnatural hardness, and frequent infections requiring their removal. The Cronin preformed silastic mammary prosthesis obviates all these complications and disadvantages, even to those of infection, since it is autoclavable as any other surgical instrument. It may be inserted immediately after simple mastectomy as advocated by Wagner[11] or as a delayed, two-stage procedure, as employed by Kelly.[10] The advantages of immediate or primary replacement are patently obvious to delayed replacement and require no further discussion except that in cases where infection does develop, the surgeon can keep in mind that the prosthesis can be removed, the infection cleared, and the prosthesis sterilized and reinserted at a later date and the patient none the loser.

In only one case out of 25 did Wagner[11] have to remove a prosthesis because of infection and this was felt to be a case of "over-stuffing" the evacuated breast with a prosthesis that was too large, with subsequent leakage and secondary infection. This temptation must be studiously avoided! In those cases where infection does develop, lavage with appropriate antibiotic solutions as advocated by Perras[8] may be attempted before removing the prosthesis.

Fear of cancer developing later in a breast in

which a prosthesis is employed is dispelled by the experience of Pangman[5] who found that only one patient developed cancer of the breast in a series of over 480 prosthetic implants over a period of 13 years — less than the national average. These cases represented the use of polyplastic silicone prostheses, which are even more reactive than the Cronin prosthesis. He also inserted prostheses in 5 cases of early, non-invasive carcinomas of the breast! The author does not concur in this latter procedure.

Technique and Surgical Implications

Prior to admission to the hospital the patient is thoroughly acquainted with what is to be done, how it is to be done, what complications can occur, the detailed after care of the procedure, and the end result to be expected. Of all the steps in the procedure, this is probably the most important and cannot be over-emphasized. Two days prior to admission the patient is started on a broad spectrum antibiotic in the usual doses; the author uses Tetracycline, 250 mgm four times a day. The night before surgery the patient takes a Hexachlorophene shower, rinses, lathers the body again and sponges herself off without rinsing, and a sterile towel is taped over the operative area and left in situ until the patient is prepped in surgery. The morning of surgery, Tetracycline, 500 mgm. is given two hours pre-op and the usual pre-op medications are given.

Following the usual prep done most thoroughly by the prep nurse and the usual draping, a submammary incision is made one and one-half centimeters above the submammary fold with a slight extension up toward the axilla laterally. The incision is so placed in order to assure good closure without the prosthesis resting against the incision but rather to rest against the lower angle of the dissection of the lower flap so formed when the patient is in the upright position. Dissection is carried down to the pectoral fascia around the breast inferiorly and then the breast is elevated in toto from the pectoral fascia. Dissection proceeds cautiously downward along the anterior surface of the gland leaving approximately one-fourth inch of subcutaneous fat on the overlying skin. This thickness is especially important in the region of the areola and nipple where the blood supply is so critical. The entire gland is removed and submitted to the pathologist for immediate examination and frozen sections as indicated. Meticulous hemostasis is secured by fine catgut ties and hot packs. Coagulation hemostasis is not employed for fear of damage to the overlying skin.

The Cronin prosthesis is then placed in the cavity with the tip of the prosthesis pointing up toward the shoulder to duplicate the contour of the normal lingula of the female breast. Here it must be emphasized that the breast cavity should not be over-stuffed. It is better to use a smaller prosthesis than an over-sized one so there will be no tension on the suture line to predispose to separation of the incision line, leakage, and the inevitable infection that will follow. Two Hemovac tubes are brought out through the lower flap, placed on each side of the prosthesis, and sutured to the skin as shown in Figure 1. Suction at 120-140 mm. Hg. is applied immediately to the Hemovac tubes and maintained for seven days. The incision is then closed in two layers using fine catgut subcutaneously and fine interrupted silk or other non-absorbable sutures to the skin as illustrated. A thin dressing is applied to the operative area without pressure.

Postoperatively, suction is maintained for sev-

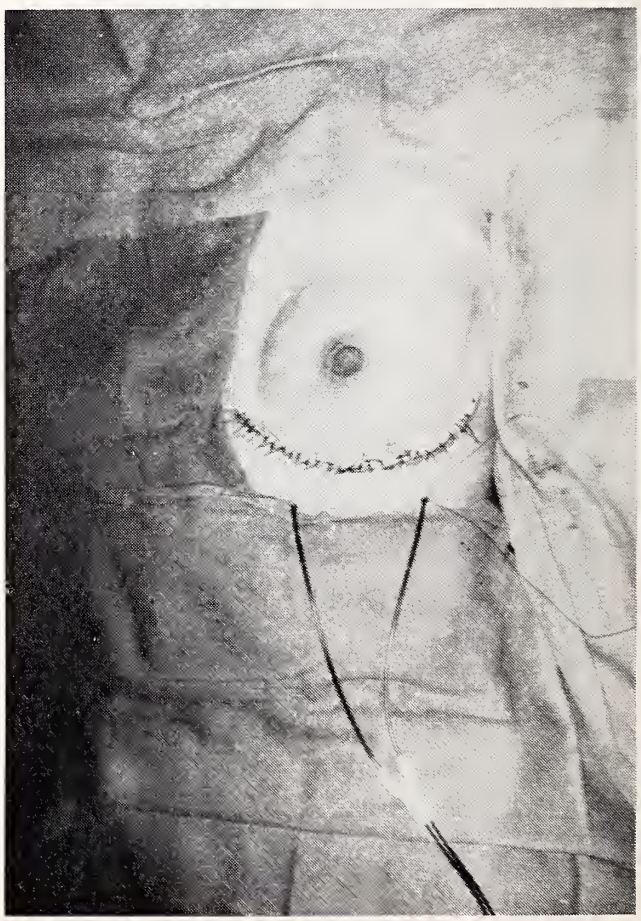


Figure 1

en days as there is a large transudate into the operative area, the patient is kept flat on her back for three days in order for the prosthesis to fix itself to the chest wall, antibiotics are continued until bi-weekly aspirations show no further fluid formation, and a light-weight ice pack is usually kept over the breast for three days. The use of an ice pack is felt to be most crucial at this stage in order to reduce the oxygen demand of the upper skin flap during the first few days after the procedure until collateral circulation can develop. Arm motion on the operated side is prohibited for three days and restricted for seven days thereafter. Sitting is allowed on the fourth day and ambulation on the sixth day. The sutures and suction tube drains are removed on the seventh day and the patient is discharged.

The patient is cautioned not to wear a brassiere of any type for four weeks, and is discharged on Orenzyme, 2 tablets four times a day, and Hydrodiuril 25 mgms twice a day, empirically, until there is no reaccumulation of fluid.

The patient is seen in the office twice weekly after discharge for aspiration of the breast under strict aseptic precautions. These routine bi-weekly aspirations are most important as shown by Perras[8] who had no infections after instituting routine aspirations in a series of 838 implants. The patient is seen at progressively longer intervals after aspiration is no longer necessary, and at six-month intervals thereafter.

Illustrative Case

W-J #34303, a 26-year-old nulliparous white female presented herself in the office on 9/12/63 with a discrete, firm, rubbery, unattached, 2 cm. mass in the lower outer quadrant of the left breast of about 2 months duration without evidence of axillary metastases. She gave a past history of three previous benign biopsies in the same quadrant in the past 2 years and of extremely tender breasts at her period times since early puberty. There was no response to daily doses of testosterone for five weeks while awaiting surgery, so that excision biopsy was performed on 10/18/63. This was reported back as "benign fibrocystic disease and encapsulated myxomatous fibroadenoma, benign, of the left breast." Her convalescence was uneventful.

She returned 11/23/65 with an almost identical mass in the same area with no suggestion of axillary disease. No fluid was obtained on attempted aspiration. Surgery was deferred at the patient's insistence until after the holidays, and again there was no response to daily testosterone sublingually. Excision biopsy was done for the fifth time on 1/3/66. The pathologist reported "Cellular fibroadenoma, benign; sclerosing adenosis and squamous cell metaplasia of the ducts of the left breast" with the comment that the "lesion may represent an early phase of cystosarcoma phylloides" — a type of degenerative fibroadenoma. The convalescence was uneventful.

A sixth excision biopsy of a similar lesion in the same location was performed on 7/5/66. The pathologist diagnosed "Cystosarcoma phylloides with focal areas of sclerosing adenosis, benign." Her convalescence was again uneventful but at the time of discharge, she was advised to consider Simple Mastectomy and Primary Replacement Mammoplasty in the event of need for further surgery.

She returned 11/16/66 with a 3 cm. firm mass in the lower outer quadrant of the left breast and accepted the recommendation for Simple Mastectomy and Immediate Replacement Prosthesis. This was performed on 12/30/66 following the preparation and technique as described above, inserting a small size Cronin prosthesis. After leaving the hospital she was aspirated twice weekly, the first aspiration obtaining 160 cc. serosanguineous fluid, the second 200 cc., and decreasing thereafter until the last aspiration on 1/24/67, which obtained only a few cc. of clear, yellowish fluid. Figures 2 and 3 taken 1/10/67 shows the breast after the second aspiration with some superficial necrosis of the nipple (which cleared without event with local applications of Tincture of Merthiolate) and nonallergic tape applied along the incision site to promote softening of the incision as well as over one of the aspiration sites. Figures 4 and 5, taken 4/25/67, show the end result approximately four months postop.

Her last visit to date was on 8/26/68 when there was no essential change in the appearance of the breast. The breast was softer, had a natural feel comparable to the right breast. She and her husband were delighted with the end result. The patient was participating in active sports such as bowling, and swimming, and there was no sign of recurrent disease in either breast area.



Figure 2



Figure 3

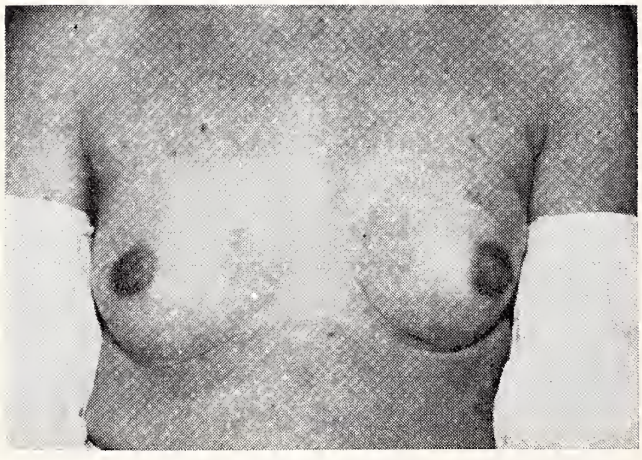


Figure 4

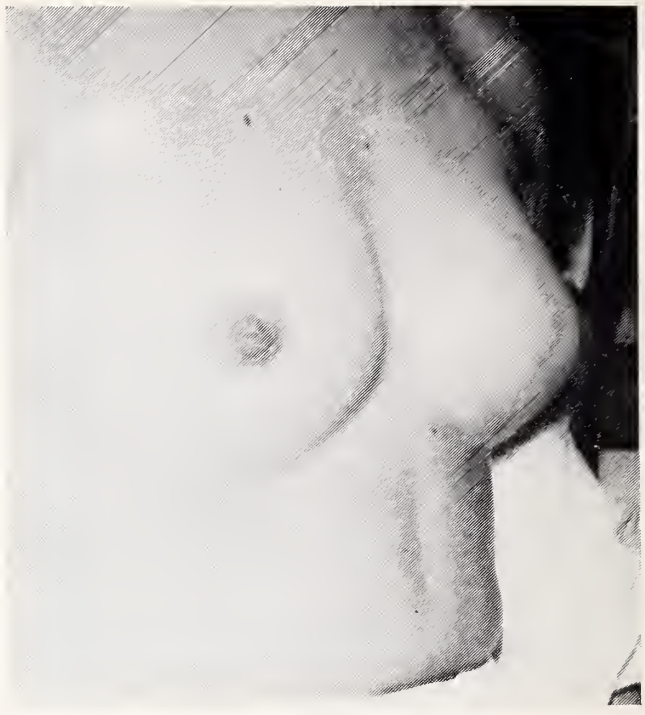


Figure 5

Comment and Conclusion

Mastectomy in the female can be a most traumatic and disfiguring event in the life of a woman. However, it need not be so any longer since the advent of the Cronin silastic mammary prosthesis. Simple mastectomy with the immediate insertion of this prosthesis may now be offered to the female patient facing recurrent biopsies of the breast. A good result may be anticipated in the majority of cases. The preoperative, operative and the postoperative care are presented with an illustrative case.

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President's Page

A New Function For Your Association

Several months ago ArMA was informed that it was named in a will to receive one-half of the estate on the death of the benefaetress. This money was to be used for seholarship grants to worthy medieal students. While your Assoeiation is a tax-exempt organization for business purposes it is not elassified as a eharitable organization for estate tax purposes. In order to gain maximum dollars for the stated purpose it was recommended by our legal eounsel that a eharitable foundation be established.

After necessary researeh a non-profit organization named The Arizona Medical Association Foundation was formed. The first meeting of this Foundation was held on July 24, 1968. The Board of Direetors of ArMA will serve as the Board for the new Foundation. Sinee that date the Internal Revenue Serviee has elassified the Foundation as a tax-exempt charitable organization.

ArMA is grateful for the stimulus provided by this bequest to form sueh a Foundation. Separately, or in eonjunetion with our existing ArMA Scholarship Fund, we ean continue to broaden our base of support for Arizona medieal students.

While the original bequest specified the monies be used for "worthy medieal students," future bequests may be made for any eharitable purpose. All inquiries should be direeted to The Arizona Medieal Assoeiation Foundation, 4601 North Seottsdale Road, Seottsdale — a new service by ArMA for the benefit of all Arizona.

ARTHUR V. DUDLEY, JR., M.D.
PRESIDENT

DEPARTMENT OF COMMUNITY MEDICINE – PART I

As all physicians know, instruction in medicine is distinguished from instruction in any other discipline or profession because medicine must be practiced in order to be taught. The most useful laboratory for this purpose is the hospital. Not all hospitals are equally satisfactory, however, since most hospitals were brought into existence for purposes other than to serve educational programs. This is why colleges of medicine developed their own teaching hospitals. The essential difference between a teaching hospital and most other hospitals is that the teaching hospital is primarily oriented to its academic community while other hospitals are oriented to patient needs.

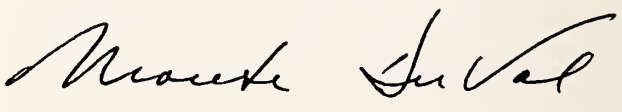
It has never been desirable for teaching hospitals to compete with adjacent community hospitals for patients. Thus, university hospitals tended to become "extensions" of physicians and facilities located elsewhere, emphasizing advanced types of services that often are not available in community hospitals. This evolution yielded a concentration of patient material of a particularly exotic and complex nature within teaching hospitals. Because of this, such hospitals are now somewhat less desirable as laboratories for undergraduate medical instruction because they contain almost no patients of the type that most physicians see in their day-to-day practice; although they are superb institutions for graduate medical education.

An appropriate way to balance the specialized influence of the university hospital in undergraduate medical education has not been devised. In Arizona, we are persuaded that the key to meaningful undergraduate instruction is the ambulatory patient who is still a part of the family unit. There are only two places where we might find enough patients of this kind for the students: the offices of local physicians and the out-patient department of the Pima County General Hospital. There are too many complexities involved to consider using the offices of practicing physicians for undergraduate medical instruction, but the out-patient department of the Pima County General Hospital does offer certain opportunities that we are giving serious consideration to.

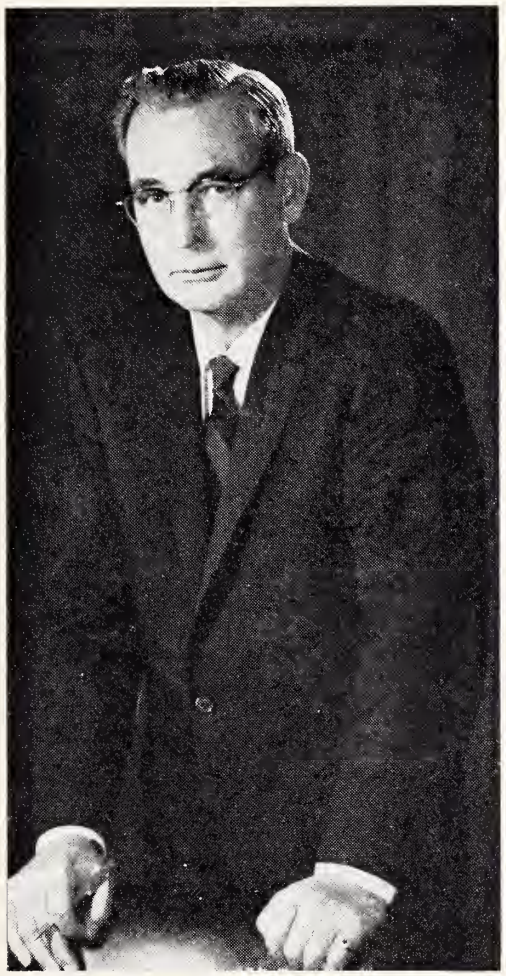
Dean's Page

Medical schools have enjoyed a long tradition relative to the use of geographically convenient, indigent populations, as a source of patients because their use does not constitute an invasion of the private sector of medical practice and the broad base of pathology usually seen in such a population is of significant educational value. On the other hand, relationships between the local units of county government that are responsible for the patients, and medical schools, have often broken down as the burden for care of the indigent patients in the community was slowly transferred to the medical school. Further, the service load itself may outweigh the educational advantages of the arrangement. A more serious objection to this practice is that it tends to perpetuate a system of medical care that is identified with the indigent – something all of us are trying to get away from.

The involvement of increasing numbers of our population in federally-financed programs of health-care has prompted us to consider seriously the possibility of establishing a Neighborhood Health Center in a poverty area. To explore this possibility, two things had to be learned. First, it was necessary to determine whether or not our community hospitals would be willing to accept, in transfer, that portion of the population which the Medical School "referred onward," especially if the Pima County General Hospital were to be closed at some date in the future (a recommendation that has been given some consideration locally). Second, it was necessary to determine whether or not our County Commissioners would be willing to join with the College of Medicine in organizing the Neighborhood Health Center. An informal meeting with the Hospital Administrators of the three major community hospitals has been held, and all have indicated a willingness to work with us in the solution of this problem. Similarly, our County Commissioners have expressed interest and enthusiasm for the possibilities that such an arrangement promises and they too have offered to be of assistance. (To be continued)



PLEASE TURN DOWN THE LIGHTS



William B. McGrath, M.D.

A previous article, "Latency Period," suggested that adults ought not keep pushing pre-adolescent boys into the constant company of girls. By the mechanism of caricature, the boy with the long hair may be expressing his unconscious protest ("Look what you have done to me") — sort of a reductio ad absurdum.

The same principle applies to the hippies. They are mocking us, showing us the grotesque results of our permissive and over-indulgent attitude toward the rearing of children.

We also questioned the wisdom of introducing or emphasizing sex education in the grade schools.

Editorial

Information about sex can be put into dainty little packages, it is true. But when the packages are opened, the contents are not just inanimate data, facts of life. Sex education can hardly escape becoming not "what is" but "how to" — a manual of operational instructions.

To the younger boy or girl this seems cruelly unfair. One would not insist on teaching a third-grader how to drive a car and then admonish him that he must wait eight years for his driver's license. A nine year old had better not be told all about sex and then required to mark time for ten long years before marrying. Let him learn the details of mating — as with driving — when he is inclined and prepared to use such information.

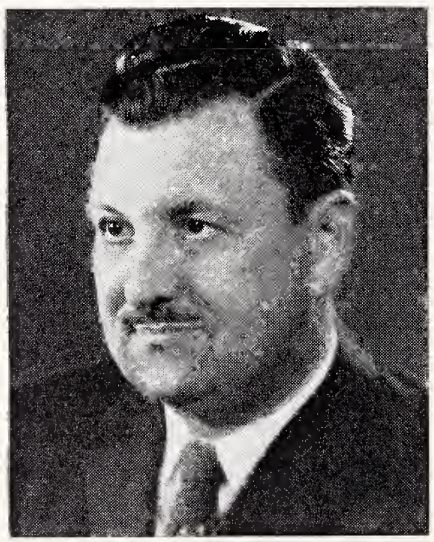
There is another, non-arguable antipathy to the current glut of sexual information and the shocking candor of its publicity. The resistance comes not so much from the acknowledged puritan in each of us but from the poet.

Sex has always been one of the mysteries, one of the astonishing beauties of human experience. If we keep pulling out and examining each thread of the tapestry, we may no longer remember the tapestry at all. In the same vein, would one not suffer a little loss in listening to an English rendition of La Boheme? If one's heart has ever been bruised by the chanting of Dies Irae at a requiem mass, he will shut his eyes to the translation.

To be other than bestial, any erotic event has to be intimate, has to be absolutely private. The sensitive person does not want to imagine — let alone talk about — the physical relationship of another couple.

Perhaps we seem to be "against" enlightenment and progress in this whole (semantic) issue of sex education. But progress is not simply constructive or additive. Something is invariably supplanted. Is it progress to scrape off the patina of propriety and good taste? Is it progress to throw away the tablecloth and dip one's hands into the entrails, the guts, of the uncooked meal? No; love will come like a doe in the twilight of modesty and not in nakedness of noon.

BASICS IN MEDICAL PUBLIC RELATIONS



JIM REED

Remarks by Jim Reed, Director of Communications Division, American Medical Association, at AMA Communications Institute, August 20, 1968, Drake Hotel, Chicago, Illinois.

We are concerned with some aspect of medical public relations. Public relations is an interesting activity because it deals with the public. And people are interesting.

—People like the man who wrote the internal revenue and said he had once cheated on his income tax and couldn't sleep. He enclosed a check for $25 and ended the letter, "If I still can't sleep, I'll send the rest."

—Or the man who wrote the medical society and said, "Send me everything you have on personal hygiene. I think I've got it."

—Or the woman who wrote, "Dear Doctor, Please send me some of those pills to be used in any conceivable circumstance."

What people do, what they think, and how they react are of concern to all of us.

There was a time when communicating with the public was a little easier than it is today. Although we lacked some of today's modern communications tools and techniques, the people were, in many ways, easier to reach. They had fewer things vying for their time. There weren't as many men and issues clamoring for attention and consent in the public opinion marketplace.

The world in those days seemed to be in pretty good order. From the turn of the century, man had been born into an environment, to which, if he wanted to survive, he was obliged to accommodate himself.

Well, the world no longer is tidy and well ordered in anybody's mind. It is a shrinking, fast-moving world of danger and tension permeated by nightmarish fears, characterized by dynamic change.

Attitudes have changed. When you mention

ethics, some people think you are talking about an old-time automobile.

And there's something wrong with our sense of values. Tiny Tim is paid $50,000 a week, but some people think it's wrong for a physician to make that much in a year.

Inflation is all about us. It now costs five cents to put your two cent's worth on a penny postcard.

And as if doctors weren't busy enough, now they've got to check over middle-aged men who jog. They ride sit-down lawnmowers and motorized golf carts, drive the car one block to the drugstore, and then jog for exercise.

It's hard for me to get used to the picture of the child standing at a school blackboard writing 500 times, "I will not pray in class."

There are other paradoxes.

Out of 365 days in the year, we devote one each to mother and father and seven to National Pickle Week.

We are told who won the election before the polls close. It's like reading the last chapter of a whodunit first.

We spend billions of dollars a year for defense, but we can't safely walk after dark in our own neighborhoods.

It takes less and less time to fly across the nation and more and more time to drive home from the office.

We're about to land a man on the moon, but we can't get the pigeons off city hall.

The Great Society, which set out to cure poverty, is about to cure wealth.

And how about those "talk" programs on radio and TV? They're part of the violence we hear so much about on television. The western shoot-'em-ups are mild compared with the Joe Pynes.

Today it is college in three years instead of four . . . instant breakfast . . . zip code . . . speed reading . . . and go, go, go.

It is not easy in these fast-moving times when too many are talking too much and too few are listening too little . . . to attract the public's attention or to hold its interest.

The challenge before us today is to cope with these changing times. We cannot hold to our anchors with the winds of change blowing all about us. And we cannot back into the future looking wistfully at the past — as tempting as it might be.

Just as the medical profession must re-examine its traditional practices to make sure they are in line with changing medical needs so must medicine's communicators tailor programs to match the fabric of the times.

In his inaugural address Doctor Wilbur discussed the importance of leadership. If the medical profession is to retain leadership in directing the course of medicine there must be effective communication.

Successful leaders of all ages from Saint Paul to Julius Caesar and from Abraham Lincoln to Winston Churchill found that effective leadership came about largely through effective communication. And they understood clearly the importance of public sentiment. More than a hundred years ago, Lincoln said, "Public sentiment is everything; with public sentiment, nothing can fail; without it, nothing can succeed. He who molds opinion is greater than he who enacts laws."

Doctor Wilbur put it this way: "Basically public opinion is the most powerful determinant and the ultimate force that in the long run will determine the social, economic, and political course of this country, and will decisively determine the future patterns of health care. The key question, then, becomes, who and what will shape public opinion?"

If we are to preserve the incentives and effectiveness of unshackled medical practice, which the medical profession believes is in the best interests of the public, then the answer to Doctor Wilbur's question is obvious. It must be the medical profession that shapes public opinion on all matters pertaining to medical practice.

In order for us to communicate effectively, so we can help to shape public opinion, we must understand the role of communications in this partnership and the limitations of public relations. We must understand what PR is and what it is not.

Unfortunately, there are still some who believe that public relations is just a device to cover up shortcomings . . . or a high-powered publicity campaign to whitewash imperfections. Public relations is none of these things.

Medical public relations is the continuous process by which the medical profession endeavors to obtain the confidence and good will of the public — inwardly by self-analysis and correction to the end that the best interests of the people will be served; outwardly by all means of

expression so that the people will understand and appreciate that their welfare is the profession's guiding principle.

Briefly stated, it is doing good and getting credit for it.

To do good without getting credit for it, is like winking at a girl in a dark room. You know what you're doing, but nobody else does.

The "doing good" is up to the profession, individually as practicing physicians and collectively through their medical associations. The "getting credit" is where the PR department can help.

Good public relations does not come from gimmicks.

It must be earned. It must be built on deeds, not words. On performance, not promise.

Hokus-pokus will not alter public opinion. And a lot of politicians are going to find that out come November. They will be voted out of office with the help of many who voted them in . . . because what the public interprets as being in its interest today may change next week.

The people still decide what's good for them. And even paid advertising can't sell them something they don't want — and the Edsel automobile is a good example.

Because the public is better educated and more interested, there will be increasing scrutiny of business and other institutions by the people to see if what they regard as the common good is fully served.

That is why the du Pont company, for example, believes that *you must live right before you tell people you are living right.*

Du Pont and many other large corporations, that once had a "public be damned" attitude, learned public relations the hard way. They learned they could not be indifferent to what the public thought of them and their deeds. That they could not function without public consent. And to obtain that consent they must act in the public interest as the public interprets it at any given time. These corporations have left in the public relations textbooks some lessons we cannot afford to ignore.

In medical associations, it is the policy-making body that determines what the organization is to do. What the association does makes an impression on the public. The impression on the public determines whether the association's PR is good or bad.

Therefore, all policy-making actions should be based on two considerations:

1 — What will the public think about this action?

2 — If this action is necessary, but likely to be unpopular, how can we "sell" it to the public?

PR should be considered before any new policy or program is developed, not used as a "mop up" after mistakes are made.

These policy actions, or programs, should be sound, honest, fair to all concerned, timely, and in the public interest. The stance should always be positive — showing responsiveness and leadership on problems people perceive and on those just beginning to emerge.

Sometimes medicine announces an excellent program that is in the public interest. But instead of getting a lot of good PR out of it, we are criticized for being so slow to respond to the problem.

The House of Delegates determines AMA policies largely on resolutions from the membership through county and state societies. The image of AMA could be enhanced if all these resolutions were meaningful, clearly understood, and contributed to the needs of the public. Unfortunately, many do not.

I recall one that was a real dandy. The medical society executive said it was sent to AMA because, as he put it, "it was too hot to handle at home." Had it been handled at home, the bad publicity generated probably would have been confined to one state. But when it came to AMA, the bad publicity was scattered over 50 states.

I mention this because concern with image seems to be a symptom of the complex society in which we live. Through incessant use, the word has become a tired cliche in the vocabulary of everyone from corporate executive to labor leaders.

Madison Avenue advertising agencies borrowed the word from psychologists — and some of them would like to give it back. And like some physicians a number of advertising men write and talk on the assumed fact that the public does not love them as well as they know they deserve to be loved.

As one advertising executive said, "If this obsession is carried too far it can detour from our professional goal which should be respect — not love."

Many articles on image are written by physicians or based on interviews given the press by doctors . . . and they lament "the shocking erosion of the doctor's image."

It is one thing to discuss your image and what to do about it among your colleagues in a closed medical meeting, but quite another to tell the public your image is slipping. If they tell the people often enough that your image is bad, eventually they might believe it.

Most of the articles on this image business state categorically that "people love and respect their own doctors, but dislike doctors and doctor organizations."

Let's examine that statement.

In every study on prestige or public esteem, physicians rank first or a close second among all occupations.

In public opinion studies made at regular intervals so ground gained and lost can be analyzed, the reputation of physicians has slipped in several key areas which come under the heading of physician-patient relations. The public's criticisms concern fees, long waits in the reception room, poor diagnosis, too little time given the patient, impersonal attitude of the doctor, difficult in seeing a doctor, and so on.

We all know that the march of science has altered this relationship and that some of the criticism is due to misunderstanding, but nevertheless this is public opinion and it concerns individual physicians.

To build a public relations program on the premise that the physician's image is slipping solely because his medical organization has a bad image, would not be getting to the root of the whole problem.

Until times change even more than they have, the foundation for sound public relations in medicine remains the individual human relationship between physician and patient. It has been said that the voluntary association of two men, one giving and one seeking relief, is the heart of the art of medicine.

What about AMA's image?

When Gallup asked the public to voice its opinion on eight national organizations, AMA placed second to the FBI.

When Opinion Research Corporation asked the public which organization had done the most to improve the health of our nation, AMA came out on top.

Yes, but someone says medicine's leadership is not what it used to be.

In mid-June, the Louis Harris Survey asked the American people this question: "Compared with what we have produced in the past in this country, do you feel that our present leadership in these eight categories is better, worse or about the same as we have produced in the past?"

The eight categories were medicine, science, business, newspapers and magazines, arts and entertainment, local government, federal government and politics.

Medicine came out on top by a wide margin. 88 percent said medicine's leadership is better. But get this: Only 43 percent said those in charge of the mass media are better. Politics was at the bottom of the list with 13 percent; the federal government just a shade better at 19 percent.

Mr. Harris said, "Medicine and science clearly are the new 'sacred cows' of American society in the late 1960's."

We should not confuse what some members of the press, some labor leaders and some politicians say about the medical profession and the AMA with the public's opinion. It's the public opinion that counts.

And in the image and prestige studies, you will find, almost without exception, that medicine's critics rank low on the totem pole of public esteem. They have a credibility gap. And as a result, their charges against medicine have not had a great effect on public attitudes to date.

All of this does *not* say that the image of the individual physician and his medical organizations is bright and shiny and that we should enjoy the coziness of the status quo. It does say things are not as bad as they may seem and that this is no time for panic and sagging morale.

It is a time for leadership and action. Time to approach sound communications programs at all levels of medicine with vigor and foresight. For while we have a strong foundation on which to build, criticisms if voiced often enough and long enough will begin to wear away at the image just as drops of water finally wear away a stone.

We must give more emphasis to public relations in the area of physician-patient relations. It is hard to believe that in this day of transplants, modern drugs and new tools and techniques which physicians are using with astounding success, that the legend of Dr. Christian ar-

riving at the farm house at midnight in a blizzard with orders to "boil some water," still haunts the profession. Somehow we have failed to help the patient to realize that the new doctor and the old doctor is and was the product of his time. And these times, as I tried to point out in my opening remarks, *are* different.

Yesterday's physician was personally in contact with the patient and the family. They saw him, heard him, talked to him, as he tended to almost every phase of medical care. Today, in general, where the personal touch is still in evidence, the patient still has an affectionate feeling toward the doctor. It's quite natural, however, that he is less likely to be affectionate toward the doctor he never sees — or can't remember seeing — the pathologist, radiologist, and some of the other specialists. When he receives a bill "for services rendered" from a physician he never heard of — and that happens frequently — there is a reaction.

Time is a scarce commodity, but if the family physician would explain to the patient the significance of the roles of the other physicians in modern medical practice, PR would be improved.

Even as times change, some things remain the same. And some of the basic fundamentals of medical public relations still are important — if we are to listen to what the public is saying.

Practicing good medicine, truly caring for the patient as a whole human being, wisely handling fees and their payment, telling the patient more about his illness, explaining why the doctor can do more for the patient in the office than on a house call and why house calls cost more, scheduling appointments to eliminate long waits in the reception room . . . these and other factors vital to good physician-patient relations still constitute about 90 to 95 percent of the doctor's PR.

Remember what Jenkins Lloyd Jones, the Oklahoma publisher, told this Institute in 1964? He said, "You gotta have heart. Your genius is conceded. Your techniques are admired. Your researches are held in awe. But these things won't save you from the smothing embrace of the Welfare State. It is your heart you have to prove."

One prominent physician, when asked for the secret of his remarkable popularity with patients, defined it this way: "It's easy. All I do is to visualize myself in the patient's shoes and treat myself accordingly." Do unto others as you would have others do unto you, is a golden rule for public relations, too.

As we plan public relations programs at the medical society level to fit in with the changing times, we should not neglect the cornerstones designed to meet an important PR need and to eliminate sources of criticism by the public. These include provision of emergency medical care on a round-the-clock basis; a grievance committee to hear patients' complaints; development of good working relations with newspapers, radio and television; an active speakers bureau suplemented with other health education activities; orientation programs for new society members; public service projects, and community relations programs. These basic programs, of course, should be supplemented by those that fit into your overall constructive PR plan.

It isn't enough that you have emergency care programs and grievance committees. The public must know about them and how they work. If the people do not know that your society is a good citizen of the community, you are no further ahead however well you try to conduct yourself. The doing must be supplemented by the saying.

And how well we communicate our story often depends on how well we use words. What may be crystal clear to the sender of the message may not be clear to the receiver.

You may have heard the story about the World War II correspondent who was writing a personality sketch on General Mark Clark. He had most of the information he needed, but there was some question about the General's age. So he wired command headquarters in journalistic cablese: HOW OLD MARK CLARK? And the reply was just as efficiently cabled back: OLD MARK CLARK FINE. HOW YOU?

Like the tango, it takes two to communicate. There can be no effective communication without reception.

At all levels of medicine we need to make sure that our communications are clear, that we say what we mean, and that the receiver will get the message intended for him.

Phraseology is important, too.

We should refer to the doctor's outer office as a "reception room," not a "waiting room." And when we use "organized medicine," instead of the "medical profession," we play into the hands

of those who like to refer to it as a "powerful union of doctors."

There seems to be a notion, too, that if a document is to be important it must be long. In fact, some of our reports and studies appear to have been prepared by the pound, rather than by the page.

There is absolutely no validity to the notion that importance and length go together.

Lincoln's Gettysburg Address contained 266 words.

The Declaration of Independence 1,238 words.

But a World War II manual on pricing cabbage contained 27,600 words.

Newsletters are read because they are brief, to the point. But there are two-pound documents collecting dust on the shelves of every medical society in the land.

There's a reason why the word "verboten" follows "verbosity" in the dictionary.

Here are some other areas that I believe deserve attention if we are to improve our communications and public relations:

We should establish public relations courses in all medical schools. The other two ancient learned professions instituted PR and journalism courses in their schools years ago.

We should get the facts on the economics of health care so we do not have to rely solely on facts and figures compiled by others. Too often statistics gathered by others are used like a drunk uses a lamp post — more for support than for illumination.

We should try to instill in all physicians and in all members of staff a public relations point of view — some term it public relations thinking. Practically everyone connected with medicine is a communicator in one way or another and all statements should be in keeping with the association's clearly defined policies and objectives.

It would be much more desirable and in the long run much more productive if physicians, who criticize medicine, would confine their criticism within the house of medicine where something can be done about it, instead of taking it first to the *New York Times.*

We must work toward the day when there will be a place in the schools of medicine, nursing and those allied with the health field for all qualified students who desire to enter. A recent national survey showed that 2,400,000 teenage girls want to become doctors or nurses. Will there be a place for those who are qualified, or will they be forced to choose other careers at a time when medicine desperately needs them? Th biggest contribution we can make today to medical public relations is to get behind the program to get more medical manpower.

In the light of these changing times, may I recommend that you read Board of Trustees reports "B" and "C", approved by the House of Delegates in San Francisco.

All of us have seen on stage or television the juggler who spins plates atop limber sticks. He places the stick in a hole in a table, balances a plate on top, shakes the stick, and the plate spins. Then he hurries about the stage setting up other sticks and plates until the whole stage is covered with whirling platters. When a plate begins to wobble, he dashes to it, shakes the stick, and spins again.

I like to compare the juggler in this scene with the medical association executive — whether he be at the county, state or national level. The plates are programs. Every one of the dozens of programs is someone's favorite. To him, it is the most important program of all.

When one of the program-plates begins to waver, the medical society executive rushes to give it some attention by shaking the stick, and it spins again. So he dashes about to and fro giving just enough attention to each program so its supporters can see that there is activity.

The problem is simply this: *We've got more programs than we can shake a stick at!*

Some programs obviously are more important than others and deserve special attention. But it is not possible to concentrate on the important when you must keep all of the plates spinning. Furthermore, each time policy-making bodies meet they add new programs. Seldom is a program eliminated.

We cannot cover everything and do it well.

We can all improve medical public relations by sifting the wheat from the chaff, devoting our time and energies to the vital programs that meet the present and emerging needs and shelving, at least for the present, the programs that do not have top priority and are not part of a constructive plan.

These are some of the things I hope you'll consider as you contemplate your role as a medical communicator in these changing times.

Television For The Arizona Physician

Boyden L. Crouch, M.D.

Educational television for physicians in Arizona became a reality on September 14, 1966. That evening at 10:30 p.m. over Channel 8, KAET in Tempe, a series of television programs sponsored by the Arizona Medical Association, Inc., began. The programs began on September 21, 1966, over Channel 6, KUAT in Tucson. It was appropriate for Dr. DuVal as Dean of our College of Medicine to discuss the thinking behind this project. He referred to some of the pressures which are being felt by the medical profession. To quote in part, ". . . No one expects to fly with an airline whose pilots are not regularly updated. As a passenger you expect the airline to fulfill its responsibility to you. In like manner it is the physician's responsibility to see that he and his colleagues are continually updated." Indeed, there are increasing pressures from within the medical community and from patients urging the physician to keep his knowledge current.

The medical association had made an earlier venture in television. During the early 1950's a series entitled, "The M.D.'s Notebook," was presented on Channel 5, KPHO TV. It was scheduled on prime time between 9:30 and 10:30 p.m. and during the first year was sponsored by a Phoenix dairy. This program continued for over two years and developed a rating among television in the Southwest second only to newscasts. These programs were designed for public edification and included timely programs in which the doctors and community hospitals and the nursing profession participated. Mr. Julian DeVries, script director, and honorary member of the medical society, contributed considerably to the program's success. Because of its public appeal, the program was accepted by the station without sponsorship as a public service. Eventually, however, because of the "free time," the medical nature of the program gave way to other interests and the series was discontinued.

The present series of programs was intended to be a part of the continuing education process for physicians. Of course, problems and some criticism developed. To maintain the privileged nature of medical education, notice of the programs came to physicians only through the medical association. It was planned that the station would go "off the air" for a brief time before the medical program began. This allowed the viewing public to select an active channel. Since only the profession has been made aware of the medical program, the viewing was limited. Problems in developing "know how" and in obtaining satisfactory program material were met and it was decided to send regular program announcements to society members. This increased physician viewing during the 1967-68 television season and plans are being made to determine the program appeal and state coverage in the near future.

It is the intent of your committee on Medical Education through Television to present a wide variety of subjects. It is not expected that all physicians will be interested in all of the subjects presented. However, it is hoped that some physicians will be interested in all of the programs. As of the first of September, 1968, sixty-five programs will have been presented for the physicians of Arizona. There were three occasions when shipping problems prevented the showing of the program. The subject material of the programs varies widely. Approximately twenty programs pertain to cardiology and approximately ten programs to psychiatry.

The favorable response from many physicians has prompted your Television Committee to continue this effort in continuing education for another year. Some steps have been taken to explore the possibility of giving AAGP credit to those physicians who show an interest, and we invite your comments concerning this project.

No discussion of the development of continuing medical education through television would be complete without a tribute to the television stations involved. Mr. Bob Ellis of Channel 8 at Arizona State University and Mr. Frank Barecca of Channel 6 at the University of Arizona have been most helpful in getting these programs on the air. Their understanding of the problems we were facing and their patience with our lack of experience are greatly appreciated. Without the helpful suggestions and the courteous cooperation of the staffs of both these stations, the television programs for the physicians of Arizona would not have become a reality.



Social Policy For The Nineteen Seventies

Wilbur J. Cohen

We live in a troubled environment. And troubles are compounded by the problems neglected by past generations and deepened by the vast changes being made daily in our lives, our work, and our relationships to our fellow man. These problems will not vanish overnight — or even over a decade. But we have begun to deal more effectively with them in recent months. And we will do more to resolve them as time goes on.

We are encouraged by our *successes*:

- *A 30-year fight for a national health insurance program has been won.*
- *A single category of medical assistance for practically all the poor has been enacted.*
- *A regional medical program to deal with heart disease, stroke and cancer — which cause 70 percent of all deaths — has been inaugurated.*
- *Legislation to assist in staffing of community mental health centers was enacted.*
- *A 95-year struggle for Federal aid to elementary and secondary schools has been won.*
- *A teachers corps and rent supplements have been authorized.*
- *A Federal scholarship program for undergraduates was started.*
- *Federal aid for libraries has been extended.*
- *The first vocational rehabilitation amendments since 1954 have been enacted.*
- *A new immigration policy has been established.*
- *A civil rights program was enacted in 1963, and a voting rights law was passed in 1965.*
- *And we have begun to attack the root causes of poverty.*

Truly momentous measures to meet pressing national and community needs and to right many have been taken over the past five years. Only starry-eyed visionaries would have predicted six or seven years ago that all of this legislation would have been enacted by 1965.

We have witnessed an unprecedented series of legislative triumphs. But unlike Alexander, we will not weep for lack of new worlds to conquer — for the greatest *challenges* lie still ahead:

- *Our great metropolitan centers, our suburbs and small towns are suffering deep distress. Plagued by poverty, overcrowding, obsolescence, contaminated air, a shortage of water, slums, crime, segregation, and a host of other ills, all our cities have neighborhoods which are not pleasant places to live or to work.*
- *More than 30 million Americans are living in poverty in urban and rural areas — bitter observers of the growing affluence of the majority of our people.*
- *Thousands of our citizens suffer from discrimination in jobs, in schools, in hospitals and in other accommodations; they daily bear the burdens of humiliations and indignities.*
- *Even though medical research has made such suffering unnecessary, children on farms and in cities, in nearly every part of the Nation, still suffer the results of polio, measles, and PKU (phenylketonuria,*

a metabolic disorder resulting in mental retardation unless controlled through specific dietary treatment, can be detected by a simple blood test performed during a child's first week of life). And thousands suffer the results of cultural deprivation and malnutrition — also unnecessary.

- *The natural beauty of America continues to yield to the junkyard, gaudy signs, the discarded beer can, and the general clutter of an industrial society so far removed from the land that many often forget that it is the source of their strength, their wealth, and their future.*
- *Our principal waterways are open sewers, increasingly less useful to man despite our past efforts to halt the abuses of this basic natural resource.*

Fortunately, this Nation is blessed with the brains, the talent, and the wealth to find solutions to these problems.

For decades social workers and others interested in social policy have been calling attention to the social causes and effects of poverty, disease, squalor and crime. By arousing public sentiment and promoting social action, they contributed to the acceptance of public responsibility for meeting these problems.

The anti-poverty program enacted in 1964 has brought into the full public spotlight the problems of poverty, deprivation, and disadvantage, which the social work profession has been combating for decades. Poverty and dependency are now prime concerns of people in the power structure. The problems are openly discussed in the public media and debated in congressional circles.

While our population is increasing by about 2.5 million a year, our Gross National Product has been moving upward at a rate of $35 to $50 billion a year. Within a decade our Gross National Product will exceed $1,000 billion a year! We will be the first Nation in the history of the world to reach this peak of national affluence.

WHAT WILL WE DO WITH OUR ABUNDANCE?

OUT OF POVERTY

- *For one thing, we must — and we will — reduce the numbers of those living in poverty. If we accelerate the efforts already begun, the United States can be the first Nation in the world to abolish poverty. And I believe we will do just this in the next decade. We have reduced the extent of poverty from 40 percent of our population in the early nineteen-thirties to less than 20 percent in the mid-sixties. We can bring it down to less than 10 percent by the mid-seventies and virtually eliminate it in the following decade.*
- *The social security system is one of the important means that has been used to reduce poverty. But it needs to be strengthened and expanded. We can — and I believe we will — automatically adjust social security benefits to increases in earnings and to any increases in the cost of living.*
- *By new and ingenious provisions in our private enterprise, social security, and tax systems, the private and public sectors will be able to assure a minimum income to all who work, and to all those who are too sick or disabled or too old or too young to work. You may call these devices a "guaranteed income," an "annual wage," the "negative income tax," or a number of other names.*
- *Adequate housing for families at every income level will be made available and open to all, regardless of race or ethnic background.*
- *We can — and I believe eventually we will — eliminate the terms "welfare," "relief," and "categories" from our governmental programs. The State public welfare agencies will become Departments of Social Services or Departments of Individual and Family Services. They will include homemaker services, foster homes and day care for children and family home care for adults among a wide and varied range of social services, which will be available to every person in the community who chooses to use them.*
- *Instead of some sixty graduate schools of social work, there will be over one hundred such schools; and the number of graduates will have tripled.*
- *Cooperation and coordination among agencies, public and private, will enable the people to get the services they need in or near the neighborhoods where they live. There will be more neighborhood centers for health and social services. There will be many more communities with group practice plans, which will deliver high quality medical services.*

HEALTH

- *Every expectant mother will be assured access to high quality prenatal and postnatal care. And this care will reduce the number of premature and mentally retarded babies.*
- *We shall have reduced the extent of congenital blindness and deafness.*
- *The scourge of many communicable diseases including smallpox, diphtheria, whooping cough, measules and polio will be all but eliminated.*
- *Tuberculosis, with its greatest toll among the poor and ill-housed, will be cut by three-fifths.*
- *The virtual eradication of syphilis will have been achieved.*
- *We will bring within the reach of every individual the artificial heart, the artificial kidney, and transplanting of vital organs which will conserve the lives of many who today die prematurely.*
- *We will have wiped out the morbidity and mortality differentials which now exist between white and nonwhite persons.*
- *Life expectancy at birth will increase from 70 years at present to 71 years by 1970, to 72 by 1975, and to 73 by 1980. And I believe we may eventually find the means to increase life expectancy to 75 years if we can find the cures for leukemia and other forms of cancer, reduce deaths due to heart disease and stroke, and reduce infant mortality.*
- *The organization and delivery of medical services will also be changed as we go along. Much better use must be made of trained professional manpower by delegating the nonprofessional aspects of their jobs to subprofessional aides.*
- *Through both private and public sources we must strengthen and expand training and scholarship programs to produce additional numbers of physicians, dentists, nurses, teachers, social workers, and medical technicians needed to provide new and more services, some of which will be startlingly different from the services available today.*
- *We will have increased the number of medical schools from 86 to over 125, and we will have expanded the number of their graduates.*
- *Nurses will be earning higher salaries and there will be more of them so that some of the shortages which exist today will be much less acute.*
- *And the miracles of modern medicine will be available to all, through private and public insurance arrangements, irregardless of race, or color, incomes or any other factor considered a medical necessity. Insurance will cover practically all major medical costs for virtually the entire population.*
- *State health and welfare departments will be working closely with voluntary agencies in providing people with access, on a voluntary basis, to family planning services, which will stress family responsibilities.*
- *These agencies will also be cooperating to provide homemaker and visiting nurse services to every family requiring such services, thus reducing the need for hospital and institutional care.*
- *A worldwide health campaign will eradicate other diseases, such as smallpox, malaria, and cholera, from most places on the face of this planet.*

EDUCATION

- *The continuing increased investment in education growing out of recent legislation will bring about a sharp reduction in the number of those who are educationally disadvantaged. Currently, 1 million students drop out of high school every year.*
- *Their unemployment rate is 27 percent, compared with 13 percent for those who complete high school. Reducing this rate one-third by 1970 and cutting it in half by 1975, will mean 3 million fewer school dropouts over the next ten years.*
- *School segregation, whether effected by open discrimination, gerrymandered school districts or ghetto housing, will have crumbled before the combined forces of legal barriers to official segregation, open housing policies, urban development, metropolitan planning, increased employment opportunities, and not least of all, the moral force of enlightened public opinion.*
- *In the next few years we will accelerate the expansion of educational opportunities for Negro students and other minority groups. This should make it possible by 1975 for*

every high school graduate to have the actual equivalent of a first rate high school education. As it is now, many complete 12 years of schooling in inferior schools and emerge with the equivalent of perhaps a seventh grade education. Such a result will become a relic of the past.

- *We will have moved from 12 years of free public education to 15 years of free public education — kindergartens in every elementary school and junior colleges in every sizeable community.*
- *By the mid-1970's there probably will be close to ten million young men and women in post-secondary and higher education — in colleges, universities, junior colleges, and technical institutes.*
- *Scholarships and loans will be available so that lack of finances will not keep any able boy or girl from completing college.*
- *The quality of education will be vastly improved at every level. School curriculums will be enriched through cooperative programs with colleges, museums, libraries, public and private cultural and educational agencies and groups. The thousands of elementary and secondary schools without library books today will have them in ample supply for every student.*
- *And trained guidance and counseling personnel will be available in every school to help our boys and girls find their way into stimulating and creative activities of significance and value.*
- *Supplementary educational centers will provide special programs for both the academically gifted and the handicapped, and will furnish other resources not available in the typical school.*
- *Educational television will have developed and expanded all over the Nation with an adequate educational television system in every State. Tomorrow's television audiences will have a real choice of stimulating high-grade shows of artistic merit, creativity, and educational distinction.*
- *There will be specialists in every school to identify the emotionally disturbed child at an early stage, thus helping to prevent the Lee Oswalds of the future.*

REHABILITATION OF THE HANDICAPPED

- *A wide range of services will be available to the mentally retarded and mentally ill and their families to help them obtain the medical, educational, employment and recreational services needed.*
- *We will rehabilitate for gainful employment 300,000 persons a year, instead of the 125,000 rehabilitated last year. Many handicapped people — including the mentally retarded, those afflicted with epilepsy, and those who have undergone a period of mental illness — will be helped to become employed and to take a place in their families and communities far beyond what is done today.*

And with all of this will come a further expansion of the private sector of our economy. There will be more private health plans, more nongovernmental hospitals and nursing homes, more private physicians, dentists, and nurses, and more local home health service agencies. There will be more local community colleges, and small private colleges will be strengthened and upgraded. There will be more private pension plans and a greater degree of home ownership. There will be more private life insurance in force and larger private savings.

What I am suggesting is that we must strive for a social structure that is at once more diversified and more interdependent — a more truly pluralistic society. All in all, there will be more choices for every individual — an awesome responsibility, requiring a great degree of education and self-discipline. Diversity and interdependence must be buttressed by intelligent cooperation between business and government, and more effective governmental cooperation among the local, State, and Federal levels.

I believe that the final outcome of America's growing affluence, of our great investments in health, education, in social security and social services, will be to offer each individual a *greater freedom of choice of what he may do with his life.* And this is a freedom of choice that must extend to all of our people throughout their lives and give greater meaning to their lives. Our society must be truly open. No longer will a person have a restriction on his opportunity for education and training, or on his occupational choice because he is a member of a minority group — or because of sex, race, or place of birth, or residence.

The freedom to choose the size and spacing of

one's family must become a reality for the poor as well as for the affluent. And this choice has important implications in terms of maternal health, infant mortality, dependency, and education and training of women. With childbearing and childrearing completed by many women while they still have many active years of life ahead, the possibilities of their resuming interrupted careers or of beginning new ones, or of contributing to meaningful volunteer activities provides them with a new dimension of choice for their lives.

Increased freedom of choice will contribute to and be reinforced by strengthening the role of the family, a strengthening of parental responsibilities, continuing education, and civic obligations.

Schools and colleges will be open evenings and weekends to serve the diversified and creative needs of the whole community. Every family will have access to good books and music, more exposure to and time for the arts and the theater. A wide range of new opportunities and programs — from Head Start to the new National Foundation on the Arts and Humanities — must furnish the tools to overcome the cultural deprivation that today blights lives in millions of American homes in rural and urban slums.

The older person will not be put on the shelf at age 60, 62, 65, or at any arbitrary age. Just as our affluence will become better distributed, so also will leisure and opportunity to enjoy it be distributed over a whole lifetime. The concept of sabbatical leave periodically to enable workers to go back to school or to travel could become a reality in our lifetimes. This will become an accepted practice of private business, educational institutions and government. Older workers will have the opportunity of tapering off work in later years by continuing part-time or part-year employment without an arbitrary age limit; this is one answer to making increasing longevity more meaningful.

And to emphasize the point again: this freedom of choice must be available to all. It must embrace those sometimes forgotten people that social workers have been serving so faithfully these many years with inadequate resources in money and personnel. Making this freedom of choice a reality is truly the challenge that we face in the decade ahead.

Some will call the picture I have painted a visionary one. Others may say it is a real possibility but question the effect it will have on incentives and initiative, on work and morals. And it is true that even if the goals I have outlined were attained, all the problems that exist today would not be eliminated, not to mention those that may arise in the future.

One fact is certain: as long as there are human beings, there will also be problems. I do not doubt that we will continue to face difficulties. The threat of war and the conflicts with ideologies will probably still be with us for a long time.

The problems we face call for an educated and *adaptable society* and a *growing, dynamic, healthy economy.* We are presented with a challenge and with great opportunities.

I believe that now is a wonderful time to be alive, to work, to think, to write, to speak, and to seek and strive for new and imaginative ways to make a new and better world.

- *I do not subscribe to the pessimism of those who say there are no new worlds to conquer.*
- *I do not subscribe to the pessimism of those who have joined extremist groups because they have lost faith in people, in America, in experimentation, in the future.*

As the philosophy underlying the big changes ahead of us has come to be articulated through discussion and interpreted through recent legislation, the concept of the Great Society has emerged as one of the great social and political thrusts of our Nation's history. As I see it, this concept represents a forward movement, from a legalistic view of political and civil rights to a broader, more dynamic concept of human opportunity. Again and again, the President has expressed his belief that every child should have the opportunity to get as much education as he can handle, that poverty must be abolished, that health care must be available to all regardless of income or social level. These are goals and purposes that are at the very heart of the concerns of social policy.

Like all great ideas, this notion of opportunity and choice is as yet only imperfectly realized in our institutions and in our social structure. But the foundations have been laid and the great testing ground lies ahead of us in the coming years. So we go forward with renewed determination to set and to reach new goals for our great Nation.

Reprinted from Arizona Medicine, October 1966.

In Memoriam

EDWARD W. ADAMSON, M.D.
1879-1968

Edward W. Adamson, M.D., pioneer surgeon of the southwest, died in Douglas, Arizona, July 14, 1968.

Born September 23, 1879, in Cass City, Michigan, he entered the Medical School of the University of Michigan in 1900. Internship in the hospital of the Calumet-Hecla Mining Company, Calumet, Michigan, preceded his arrival in Douglas on May 29, 1905 to join the staff of the Calumet Hospital in the Arizona copper-smelting town.

Dr. Adamson established his private practice of General Medicine and Surgery in 1906. In 1910 he added to his responsibilities the post of superintendent of the newly-completed Cochise County Hospital, a position he held for the next two years.

In 1913 the 33-year-old physician attended a meeting of the Surgeons of North America in Chicago, and the following year he was elected a Fellow in the American College of Surgeons.

Service in the Army Air Force Medical Corps during World War I extended from 1917 to 1919 at which time Dr. Adamson was honorably discharged with the rank of Major and returned to private practice in Douglas.

While taking post-graduate work in local anesthesia in Chicago in 1924, he met an Austrian surgeon, Dr. Labat, who was demonstrating spinal anesthesia in this country. He became interested in the technique and, upon returning to Douglas, he began using the new method. He performed over 6,000 operations under spinal, one a thyriodectomy.

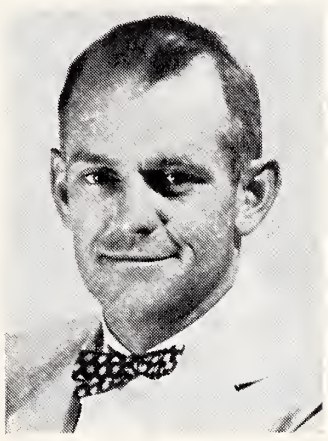
The same year the superintendency of Cochise County Hospital was freed of its bonds as a political plum. Dr. Adamson accepted re-appointment to the position, holding it until his retirement in 1962.

Private practice was again suspended when he became owner of the Calumet Hospital in 1926. He operated the facility until 1931 when the Calumet and Arizona Mining Company merged with the Phelps Dodge Corporation; resuming private practice the same year, he was active professionally until the age of 81.

Edward W. Adamson was recognized as the outstanding Arizona physician by the Arizona Medical Association in 1955 and in 1960 received the Medallion of Merit from the University of Arizona. In addition to his Fellowship in the American College of Surgeons, he was a member of the Cochise County Medical Society, Arizona Medical Association, American Medical Association and the Southwestern Medical Society. For 25 years he was physician for Douglas public schools and helped eradicate trachoma in the border city area. From 1912 to 1945 he served as Acting Assistant Surgeon, U. S. Public Health Service, examining Mexican aliens entering the Douglas port.

At the time of his death, Dr. Adamson had been a 68 year member of the BPOE; Master of the Higher Degrees of Masonry, Chapter Royal Arch and a 32nd Degree member of the Scottish Rite; charter member and 1925 president of the Douglas Kiwanis Club; six year member of the Board of Directors of the former First National Bank of Douglas.

In 1906 Dr. Adamson married Miss Florence Dillingham of Boston, Mass. She died in 1924. Miss Anna Van Brunt Foster, of New York, whom he married two years later, died in 1944. He had no children. He is survived by a sister, Mrs. Beulah LaMarche, and a nephew, James E. LaMarche.



ROBERT B. JOHNSON, M.D.
1922-1968

Dr. Robert B. Johnson was born at Twin Falls, Idaho, on August 4, 1922. He completed his premedical studies at the University of Arizona in 1940. He excelled in Varsity football and track, was a member of Bobcats (senior men's honorary), president of Alpha Kappa Kappa and president of his Junior Class. He received his M.D. degree at Columbia University, College of Physicians and Surgeons. His internship was served at Baylor Hospital, Dallas, and his residencies at St. Mary's Hospital, Tucson, and Firland Hospital, Seattle. He served as Flight Surgeon during the Korean War.

His affiliations included the American Medical Association, Arizona Medical Association, Pima County Medical Society and the American College of Chest Physicians. He was a member of the Tucson Racquet Club, and the Desert Club.

Dr. Johnson was an untiring worker in his profession, rendering the highest type of medical service at all times. He is missed by his patients and by his confreres.

Harold W. Kohl, Sr., M.D.

Letters to Editor

The Honorable Sam Steiger
Congress of the United States
Washington, D. C. 20515
Dear Congressman Steiger:

Your letter of August 21, 1967 is much appreciated. I am writing this reply while on vacation at the old Nail Ranch, about 15 miles in the Rim country, out of Young, Arizona.

As you probably know, from our mutual friend, Doctor Kahle and our common Republican philosophy, the medical profession in Arizona is concerned with ever-increasing regulatory power which the Federal Government is assigning to itself in the field of drugs and medicine.

A bad underestimate on the part of Food and Drug Commissioner, James L. Goddard and his staff, was that it would cost $90,000,000.00 for batch certification of ethical drugs of all kinds, while continuous plant inspection would add another $30,000,000.00 to $50,000,000.00. Joseph D. Cooper, Ph.D. of Howard University of Washington, D. C., says that one of the biggest problems would be to find inspectors whose training would have to come from the drug companies themselves.

The large question is, how much control is needed to assure effective control? Doctor Cooper asks; "For each additional measure of control added, does the taxpayer receive equivalent benefit? Does the insistence of the F.D.A. on more and more data lead to more rational decision making, or does it merely establish that a bureaucracy has not been remiss in covering every contingency."

"Bureaucratic regulation tends to acquire an elegance of its own — a baroque elegance. It propels into the future the protective devices engineered to assure that mishaps encountered in the past are not repeated, regardless of probability."

Doctor Cooper continues with an observation with which we most heartily agree; "Rules, regulations, record keeping, and reporting requirements grow like barnacles on the hull of a ship, slowing its passage and adding to the cost of the journey."

The question of the future, as physicians see

it, is whether or not rule-book medicine is to supersede professional judgment? Physicians know that regardless of the desirability of such a circumstance, medicine has not reached a state of being more science than art.

We are not critical in the main of Commissioner Goddard who is a dynamic individual who has made great progress in restructuring F.D.A.'s processes; but we seriously question the direction and course, and the wisdom of concentrating too much power over the rules of medicine in a single person.

Recently Commissioner Goddard asked Congress for a review of the policy that clinical data submitted by one firm cannot be made use of by another firm wishing to market the same product. This most certainly, as Commissioner Goddard himself put it, . . . "raises questions about the circumstances under which data purchased with private money shall be placed in the public domain." The Commissioner felt, however, that this was desirable and would lead to reduction in waste of scientific talent. What do you think would be the effect on drug research by the large ethical drug houses of such a change in policy? There is no question in our minds that the best control of drugs is by licensed self-regulation.

Another pronouncement on Commissioner Goddard's part came recently in San Francisco when he told a press conference that he proposed to move into the field of setting and enforcing standards of safety and efficacy for medical devices and instruments. He said he supported the Stagger's bill in the House Committee that would give the F.D.A. power to "set appropriate standards and to pre-clear *all* instruments and devices before they reach the market place." Doctor Arthur C. Beall, Jr., Baylor University Surgeon, and new President of the Association for the Advancement of Medical Instrumentation said that; "The F.D.A. has no experts competent to test new machines and couldn't hire them if they wanted to. The only experts at this stage of the game are the inventors, designers and manufacturers themselves."

Physicians resent the implication that they cannot distinguish a worthless device or a harmful one from one of value. Physicians are, by and large, the most sceptical and hard to convince group in the world when it comes to items within their professional competence. Doctors, engineers and manufacturers are quite capable of setting their own high standards and policing themselves. From the activity in Washington, it would seem that the engineers, manufacturers and doctors, who are really the gas and oil of this nation, are a lot of bumbling, unsophisticated, gullible, incompetents who require direction and regulation from on high by others who are far removed from daily clinical experience. One other point: At this stage in the development of medical instrumentation, as pointed out by Doctor Beall, the setting of standards in the field is particularly difficult, because each machine at this point is likely to be a "one-of-a-kind" model.

As another example of the concern of physicians with policies of the F.D.A., Doctor Walter Modell, Pharmacologist of Cornell Medical College, continues to press the F.D.A. to foreswear any policies that impose censorship on published discussions of drug dosages or threaten medical publishers, editors and authors with legal penalties if they stray from F.D.A. approved package insert information on drug usage. Doctor Modell has attacked as "meretricious" the F.D.A.'s "belief that this program is serving the public interest." One wonders about the guaranteed right of freedom of the press.

I notice that the House recently trimmed $524,00.00 from the F.D.A. budget and the Senate trimmed an additional $225,000.00, leaving Commissioner Goddard with $66,000,000. In Senate action, the N.I.H. budget received one-and-a-quarter billion. Add to this the cost of Medicare, the eventual cost of implementing Title 19, and it staggers the imagination!

You mentioned that the House Ways and Means Committee has been presented with a bill to allow tax treatment similar to that of corporations for doctors forming professional associations. Arizona physicians are in favor of this as evidenced by resolutions adopted by the House of Delegates of the Arizona Medical Association over several years. Such treatment is fair and equitable, and any inducement to encourage our bright young men to enter the field of medicine rather than the engineering sciences which attracts more and more of our energetic and ambitious students, would be in the public interest. The physician shortage is becoming acute, will worsen, and surely shows that the life of a physician under burgeoning controls is not

the attraction that appeals to the independent spirit.

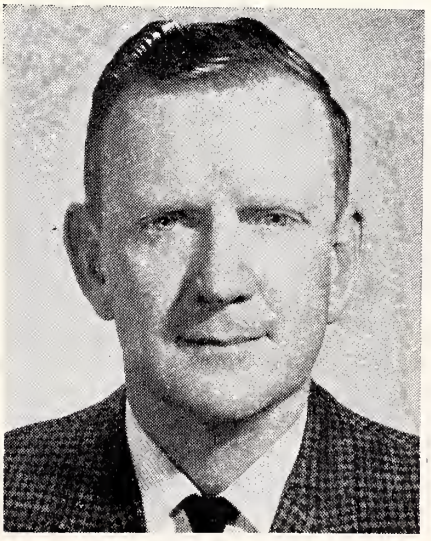
The insistence that drugs be prescribed by generic name in order to subsidize their cost is another snare and delusion. Most any practitioner will tell you that even with a common drug like aspirin, he does not get the same results from all brands marked USP. When it comes to saving a few dollars on an antibiotic that may be life saving, few physicians will prescribe an Italian import by generic name in favor of a drug manufactured by one of our trusted and well established ethical houses, or one manufactured by a fly-by-night company who spent not one cent in developing the drug or establishing standards. I'll wager that the members of the Senate Financing Committee when they buy aspirin do not buy the 9c per hundred variety although plainly marked USP. There are many considerations other than price and the assay of the chemical composition. How many steps in quality control were established? How large is the particle size? What is its solubility? What menstruum was used as a carrier or filler? How rapidly does it deteriorate? How uniform is the dose? Does it produce the same results time after time? Doctors know, do the politicians?

In regard to your report on the Senate Antitrust Committee's hearings on legislation prohibiting doctors from dispensing eye-glasses or owning pharmacies or drug re-packaging firms, I had occasion four years ago to survey the state to determine how many Arizona physicians had an interest in pharmacies. As nearly as the Medical Association and I could determine, there were only five. Two of these were married to pharmacists who were widows of pharmacists, who later married the doctors; there was a question if under joint tenancy the doctor actually had an interest in the business since his wife had her interest prior to their marriage. How are they going to legislate against something like this? It would lead to the same abuses they hope to correct. The other three owned stock in pharmacies whose major shares were held by pharmacists, who solicited the doctors to invest. How can you trust a physician to treat your illnesses and to operate upon you, but not trust him to be forth-right in any other endeavor?

As you were kind enough to invite me to write about specific things that are troubling me, I have outlined only a few that are of general concern to Arizona doctors. I would be honored and pleased to have you consult with me on matters pertaining to the practice of medicine in the future.

Yours truly,
Paul B. Jarrett, M.D.

Topics Of Current Medical Interest



James L. Grobe, M.D.

CONGRATULATIONS ARE IN ORDER FOR DR. GROBE WHO WAS ELECTED TO THE BOARD OF DIRECTORS OF THE AMERICAN ACADEMY OF GENERAL PRACTICE AT THEIR RECENT ANNUAL CONVENTION IN LAS VEGAS. DR. GROBE'S TERM OF OFFICE WILL RUN TO 1971.

Future Medical Meetings

The AAGP Proudly Presents Its

Interim

Scientific Meeting For All Doctors of Medicine On

Rehabilitation Medicine

Sat. & Sun., Nov. 9-10, 1968
CAREFREE INN
Carefree, Arizona

Schedule of Events

SATURDAY, NOVEMBER 9th, 1968

9:00 a.m. **Registration**

2:00 p.m. **Main Lobby**

10:00 a.m. **Welcome—**
C. J. Alexander, M.D.
President, AAGP

Introduction—
W. V. Edwards, M.D.
Program Chairman

"A G.P. Looks At Rehabilitation Medicine"
John B. Fenger, M.D., Phoenix

"Seminar Method of Treatment of Disability"
A. H. Hirschfeld, M.D., Detroit
Asst. Prof. of Psychiatry, Wayne State University

12:00 Noon **Panel Discussion**

12:15 p.m. **Luncheon—Ladies Included**

"Training the G.P. of the Future at Michigan State University"
Allen J. Enelow, M.D., Lansing
Chmn., Dept. of Psychiatry
Michigan State University

2:00 p.m. "Concepts of Braces and Artificial Limbs"
Sam C. Colachis, Jr., M.D.
Phoenix

"Rehabilitation of the Arthritic"
I. Medical
Sanford Roth, M.D.
II. Physical
Freeman Fountain, M.D., Phoenix

"Rehabilitation of Pulmonary Dysfunctions"
Howard Kravetz, M.D.
Phoenix

"Rehabilitation of the Cardiac"
Alan L. Gordon, M.D., Phoenix

"Know Your Nursing Principles"
Albert G. Wagner, M.D., Phoenix

Panel Discussion

5:00 p.m. **Recess**

7:00 p.m. **Cocktails**

8:00 p.m. **President's Banquet**
'A Roman Feast Beyond Your Wildest Imagination'

"Integrity"
Mr. Neal Clement, Tucson

SUNDAY, NOVEMBER 10th, 1968

9:00 a.m. "Back and Neck Problems"
Sam C. Colachis, Jr., M.D., Phoenix

"Rehabilitation of Hemiplagia"
Freeman Fountain, M.D., Phoenix

"The Price of Severe Disability"
John Young, M.D.

12:00 Noon **Adjournment**



SCIENTIFIC PAPERS
SCIENTIFIC EXHIBITS

FOR THE 1969 ANNUAL MEETING OF THE ARIZONA MEDICAL ASSOCIATION

APRIL 22-26, 1969

PAPERS:

Again this year the Arizona Medical Associaion is soliciting papers from Arizona Physicians for presentation at our Annual Meeting in April 1969. We are particularly interested in papers dealing with the Medical and Surgical Sub-Specialties and in having the Directors of Medical Education in our state's hospitals encourage the participation of their Interns, Residents and Fellows. The papers should be approximately one-half hour in length.

A brief abstract must mailed to:

Chairman — Scientific Assembly Committee
Arizona Medical Association
4601 North Scottsdale Road
Scottsdale, Arizona 85251

The deadline for consideration is December 1, 1968.

EXHIBITS:

If you have a Scientific Exhibit that you wish to show at the 1969 Annual Meeting, please forward a brief written description of the exhibit to:

Chairman — Scientific Assembly Committee
Arizona Medical Association
4601 North Scottsdale Road
Scottsdale, Arizona 85251

Scientific Exhibits are limited to booths with the following dimensions: 8' wide, 6' deep and 7' 6" high. Because of physical limitations, there can be no exceptions to these booth dimensions. The cash award provided in previous years will not be available this year. All applications for scientific exhibit space should be mailed by December 1, 1968.


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#1 Tablets
(0.1 mg reserpine and 25 mg hydrochlorothiazide)
2/3817
CIBA

Smiles speak louder than words

for the good taste of Soyalac

Milk-free, hypo-allergenic Soyalac has a pleasing taste that is eagerly accepted by most infants. It's similar to mother's milk in composition and assimilation, much like cow's milk in consistency and completely free of fibre. Extensive clinical data support Soyalac's value in promoting growth and development. Soyalac is also excellent for growing children and adults.



Available in
Concentrated Liquid or Powdered

Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.

Soyalac

a product of

LOMA LINDA FOODS

MEDICAL PRODUCTS DIVISION

RIVERSIDE, CALIFORNIA

Mount Vernon, Ohio, U. S. A.



This advertisement for TAO® (triacetyloleandomycin), published at the request of the Food and Drug Administration, replaces a recent one which the FDA regards as misleading.

The advertisement headlined "new evidence for TAO . . ." and emphasized that the drug is "for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital. *Staphylococcus aureus."

We emphasize that triacetyloleandomycin is to be used only for acute, severe bacterial infections where adequate sensitivity testing has demonstrated susceptibility to this drug and resistance to other less toxic agents. In view of the possible, but reversible, jaundice and hepatotoxicity of this drug, other less toxic agents should be used unless the organism is resistant to those agents, or in those cases where hypersensitivity precludes their use.

TAO is contraindicated in preexisting liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug.

The advertisement emphasized that no tooth staining has been reported after ten years of use of this antibiotic. The Food and Drug Administration regards this claim as an implied comparison suggesting that triacetyloleandomycin and tetracycline have a similar antibacterial spectrum of effectiveness, and that TAO has less toxic potential. Any such implication is not intended and, of course, would be invalid.

The advertisement referred to a research study in which patients were given triacetyloleandomycin prior to determining the susceptibility of the offending organism. Any suggestion that triacetyloleandomycin be used clinically without first determining susceptibility of the offending organism should be disregarded.



J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

TAO®(triacetyloleandomycin)
Brief Summary

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires reevaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

ROERIG

J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

Q. How much does the **anticostive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is
PERITINIC®
Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

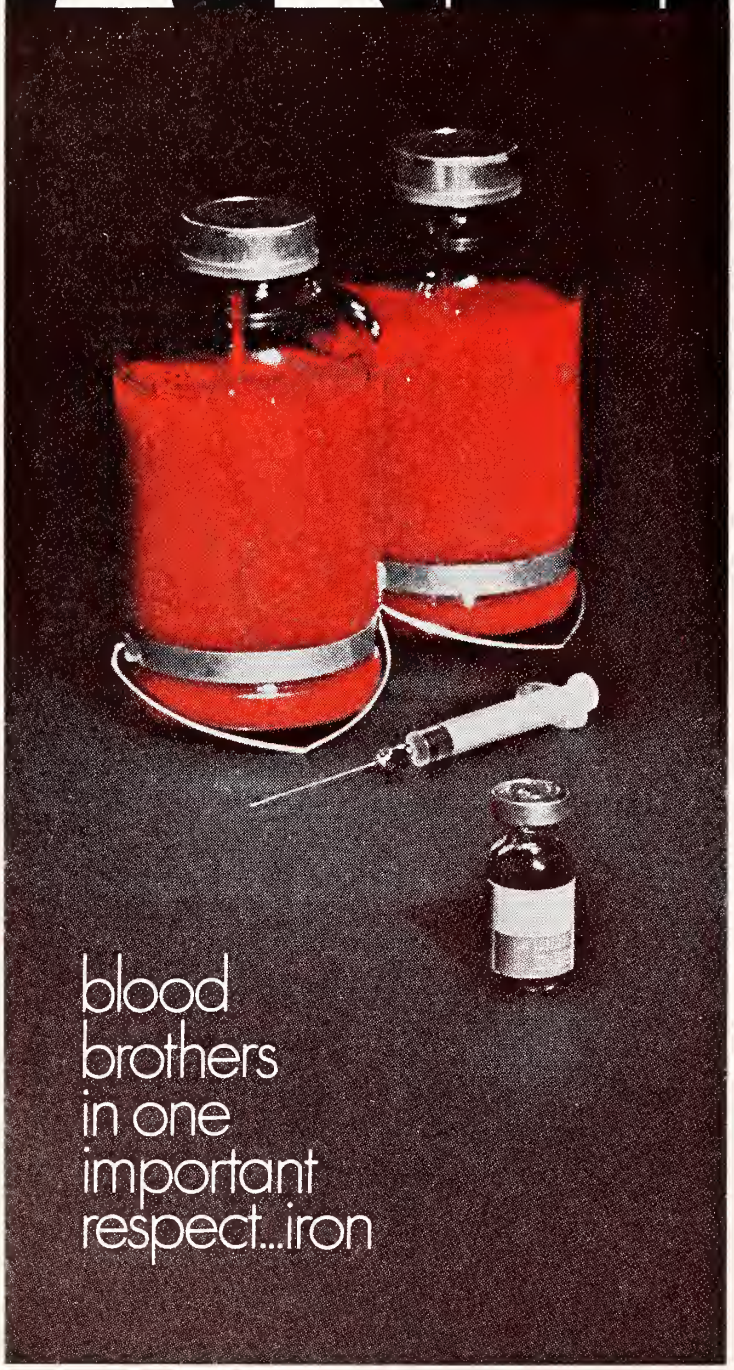
*
anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

490-7R—6064

IRON DEFICIENCY

ANEMIA



Each 10 cc. vial provides as much iron as 2 pints of whole blood. And use of IMFERON rather than whole blood for iron replacement eliminates the potential dangers of hepatitis and whole blood sensitivity reactions. Whole blood, of course, should be used if clearly indicated.

IMFERON dependably increases hemoglobin and rapidly replenishes iron reserves—for iron deficient patients in whom oral iron is intolerable, ineffective or impractical, and in those who cannot be relied upon to take oral iron as prescribed. Precise dosage is easily calculated.

IMFERON®

(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

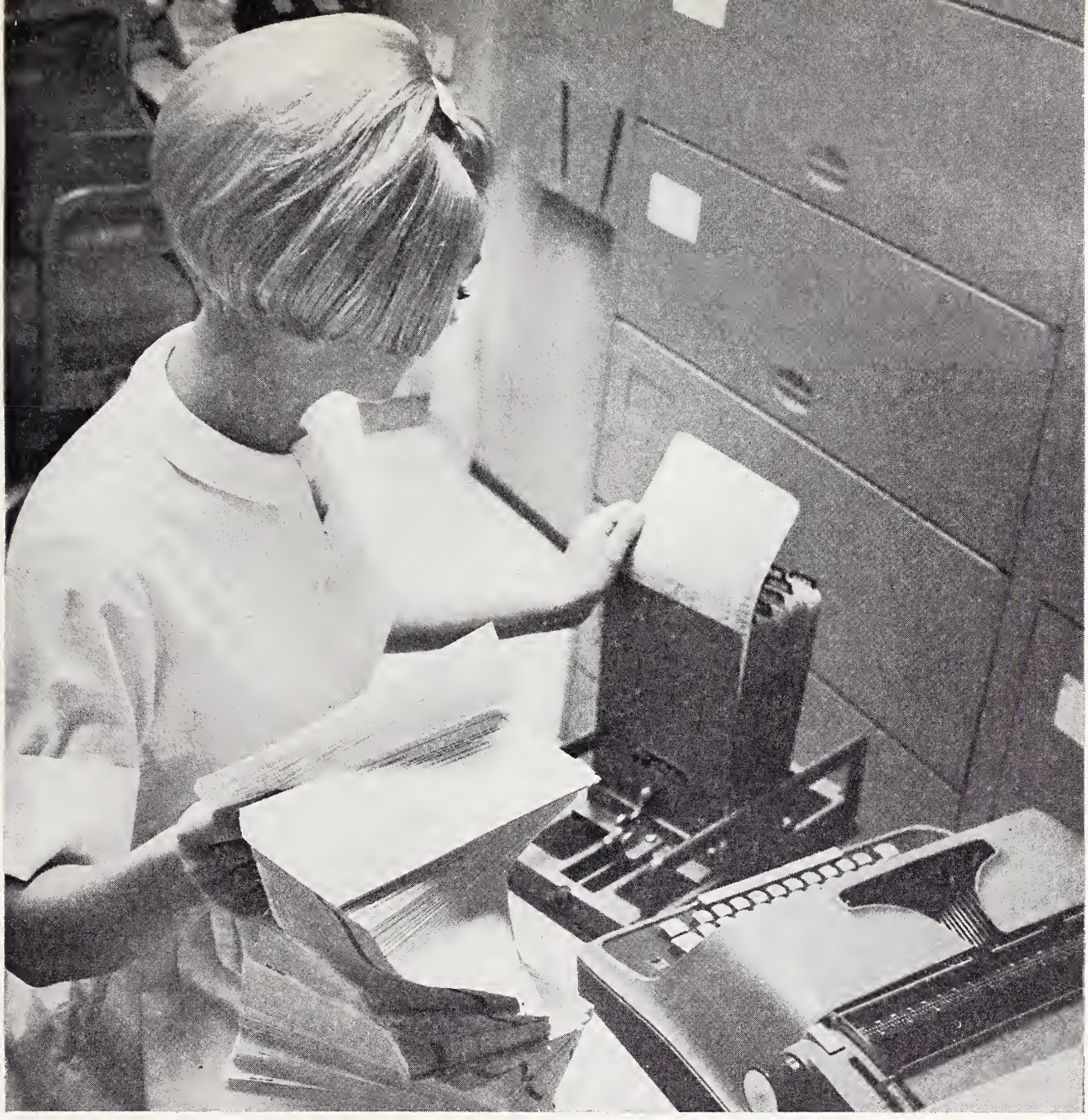
CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

See package insert for complete prescribing information.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



WHY DOES SHE DO YOUR BLUE SHIELD CLAIMS FIRST?

First of all, because they're *simpler* and take less time than most of the others. What's more, Blue Shield pays off *twice* monthly—usually before your patient-billing date. If you think we may be going out of our way to make things easy for you and your office, you're right! Because, without the help of the medical profession we could not exist! And your patients couldn't receive so many important health benefits so economically.

YOU CAN'T BEAT 'EM...SO JOIN 'EM

Blue CROSS
BLUE Shield

PHOENIX • TUCSON • FLAGSTAFF



sustained-release

Mol-Iron® Panhemic Chronosule®*

capsules

To help overcome the inadequacies of poor absorption and insipid diet common in the geriatric patient—a superior, sustained-release hematinic combined with key vitamins.

Each Mol-Iron Panhemic Chronosule capsule contains: Ferrous sulfate, 390 mg. (78 mg. elemental iron) and Molybdenum sesquioxide, 6 mg. in sustained-release form; Vitamin B_{12}, 25 mcg.; Vitamin B_1, 6 mg.; Vitamin B_2, 6 mg.; Vitamin B_6, 5 mg.; Niacinamide, 30 mg.; Vitamin C, 150 mg. Supplied: bottles of 30.

*brand of sustained-release capsule

†Parsons, P.L., Withey, J.L., and Kilpatrick, G.S : Practitioner 195:656, (Nov) 1965.

White Laboratories, Inc.
Kenilworth, N.J.

BETTER TOLERATED—HELPS ASSURE MORE PREDICTABLE ABSORPTION AND OPTIMAL HEMOGLOBIN RESPONSE

SUPERIOR TO CONVENTIONAL FERROUS SULFATE

In 'Toler-ability'

Slowly-liberated, molybdenized ferrous sulfate virtually eliminates gastrointestinal side effects.

So well tolerated it can be taken on an empty stomach.

In 'Absorb-ability'

Gradual release of better tolerated, molybdenized ferrous sulfate helps assure more predictable absorption.

In 'Dose-ability'

Just a single Mol-Iron Panhemic Chronosule capsule daily generally corrects mild to moderate hematologic and nutritional deficiencies.



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin plus belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation. A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT!
ROBITUSSIN®



THERE'S A FORMULATION FOR EVERY COUGHING NEED

All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Pheniramine maleate 7.5 mg.
Codeine phosphate 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Dextromethorphan hydrobromide . 15.0 mg.
Alcohol, 1.4%

Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

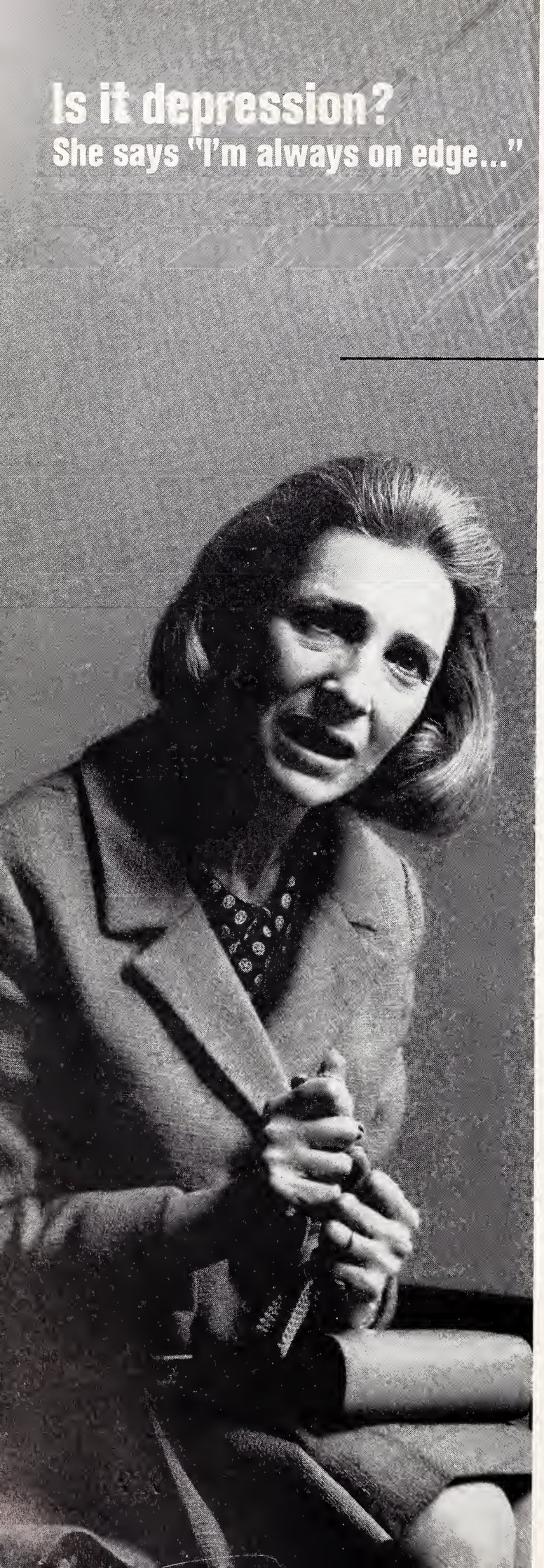
PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

Is it depression?

She says "I'm always on edge..."



...but her other symptoms:

depressed mood, insomnia, anorexia, feelings of guilt

strongly suggest an underlying depression.

when the diagnosis is depression

ELAVIL® HCl (AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

MERCK SHARP & DOHME Division of Merck & Co. Inc. West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY



When she gets a bacterial infection, think of Tetrex-F.®

Like the debilitated or diabetic patient, she may be susceptible to monilial overgrowth.

That's why she needs the extra protection of Tetrex-F whenever tetracycline therapy is indicated. Tetrex-F provides well-tolerated tetracycline phosphate complex for the bacterial infection—nystatin to help prevent monilial overgrowth.

Tetrex-F®

(tetracycline phosphate complex-nystatin)

Whenever monilia may threaten tetracycline therapy

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A. H. F. S. Category 8:12**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

WHAT SHOULD A DOCTOR'S FEE BE?

Recently we had a plumber at our house — he charged for his labor $14.00 for a half hour.

Add up the years of time, study, labor and investment made in liberal arts, medical college, internship, and possibly even time waiting to build up a practice. All of these costs should be applied against the productive years.

The dollar today is a 40-cent dollar compared to the dollar in the 40's. Even if we take the last 10 years the dollar has shrunk in value 16 cents. So apply inflation to the doctor's fee.

Deduct for high rent, office expenses and personnel. Deduct for depreciation on equipment.

Deduct for costs and time involved in government Medicare and other paper work, accounting, collecting.

These reductions and comparisons put doctors' fees in the right perspective.

How can the doctor protect his earnings? How can he protect his savings against the ravages of inflation?

When the Page Land & Cattle Co., which is an old institution in Arizona dating back to 1910, has investment potentials available for investors we customarily handle them.

The U.S. Supreme Court has stated that one may avoid though he may not evade a tax.

Breeding herds permit current deductions and ultimately capital gains on sales.

In many situations doctors are prepaying interest.

Persons who have gotten lands from Page Land & Cattle Co. have generally done well — capital gains-wise.

Protect your hard earned dollars. Give us a call or send us a card and we will meet with you at your convenience at your office or your home.

HELMICH INVESTMENT CORPORATION

520 LUHRS BUILDING
PHOENIX, ARIZONA 85003
TEL. 253-0713



The casual atmosphere
of Camelback Hospital
is one of relaxed Western living.
Looking east, Camelback Mountain provides the background
for the lovely lawn and grove area.
The natural beauty of the surroundings at Camelback Hospital
creates, for the patient,
a restful, scenic setting.

Camelback Hospital

5055 North 34th Street
955-6200
PHOENIX, ARIZONA
ARIZONA FOUNDATION FOR NEUROLOGY AND PSYCHIATRY
A Non-Profit Corporation

Located in the heart of the beautiful Phoenix citrus area near picturesque Camelback Mountain, the hospital is dedicated exclusively to the treatment of psychiatric and psychosomatic disorders, including alcoholism.

APPROVED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS; and THE AMERICAN PSYCHIATRIC ASSOCIATION

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

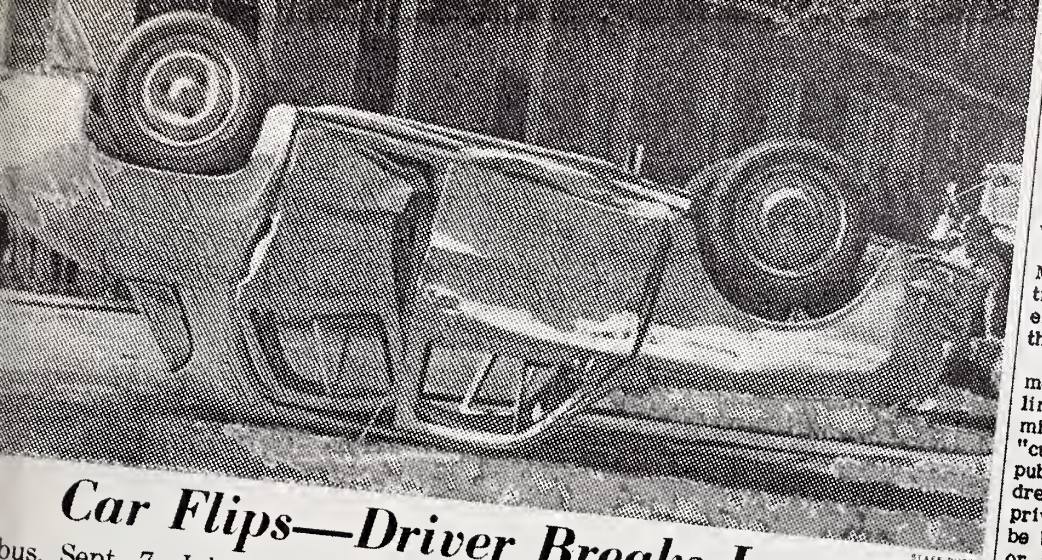
Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

348-8



Car Flips—Driver Breaks Leg

bus, Sept. 7. John P. Jones of
Lane incurred a broken leg today
he was driving failed

Patrolman B. R. Brown, the car hit a
fire hydrant and flipped over on its top
Hasn't he had enou[illegible]xciteme

STAFF PHOTO

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He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

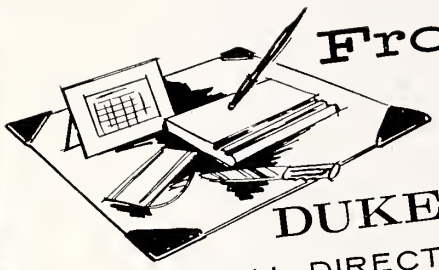
Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (¼ gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220 A·H·ROBINS





From The Desk Of

DUKE GASKINS, M.D.

MEDICAL DIRECTOR, HBA LIFE INSURANCE CO.

Doctor:

There's no paper blizzard at HBA.

If you're like me, you got enough paper work in med school to last a lifetime.

But let's face it. The tempo of the times, and specialization in our own profession, has made the written word a fact of life.

In only 5 out of 100 claims it is necessary for HBA to bother the doctor for additional information on a patient. You'll find the forms simple and straightforward.

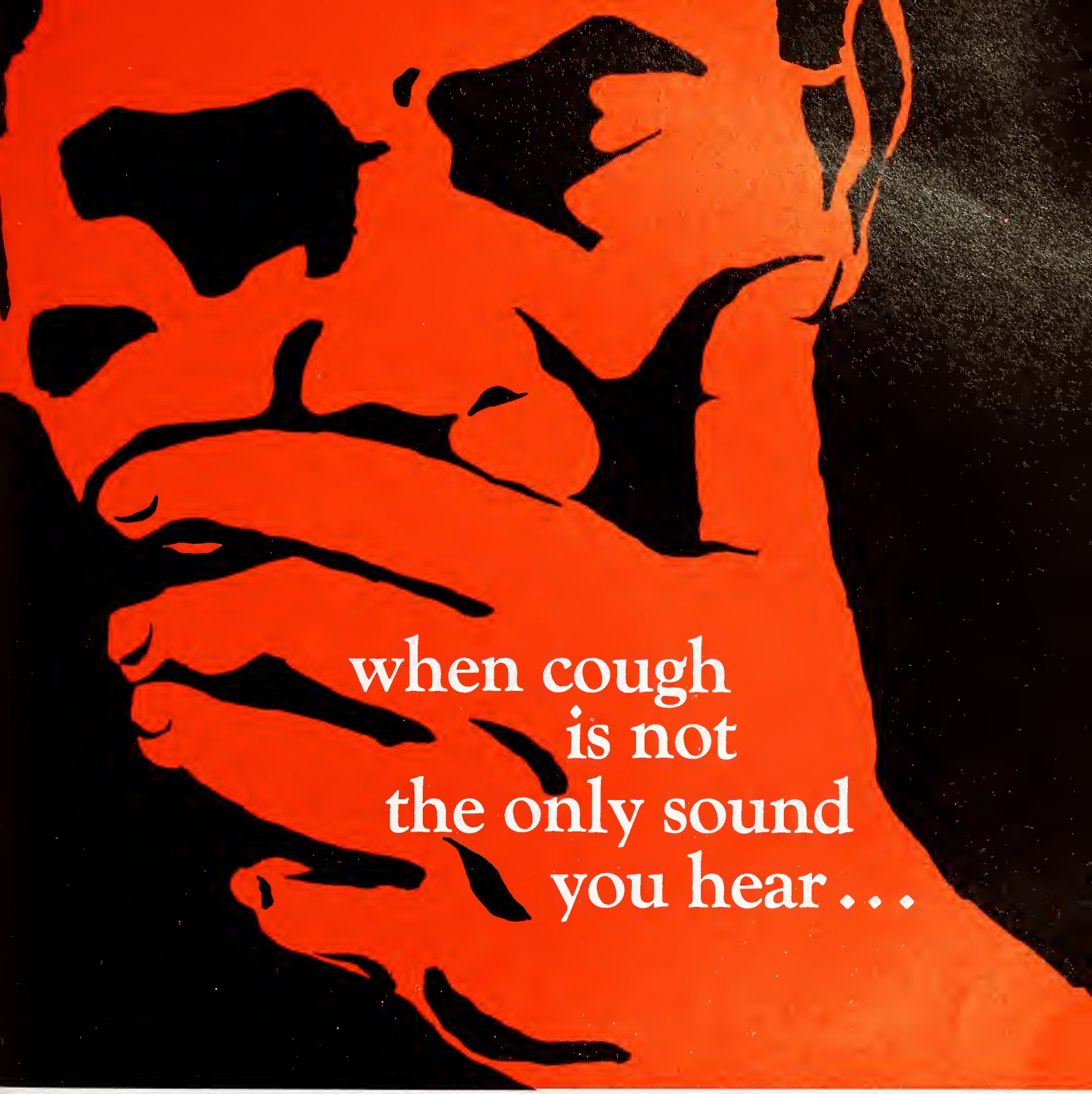
Figure when your patient asks you to complete an HBA form, we needed it! We'll appreciate your promptness in returning the completed form.

Duke

THE HBA LIFE

INSURANCE COMPANY

GROWING WITH THE ELEVEN WESTERN STATES



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*)*:* ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

He isn't burdened by his hypertension or his therapy...



Butiserpazide® lowers blood pressure so smoothly that patients are often untroubled by either the disease...or treatment

BUTISERPAZIDE provides not only the classic thiazide/reserpine formula; it supplements it with the mildly sedative effect of BUTISOL (butabarbital).

Clinical comparisons have shown that many patients respond to this treatment with (1) smooth, uniform lowering of blood pressure[1]...at times *below* the levels attained with previous therapy[2]; (2) "striking" improvement in such symptoms as headache, nervousness, palpitation and dizziness[2]; plus (3) "...lowered incidence of drug side effects."[2]

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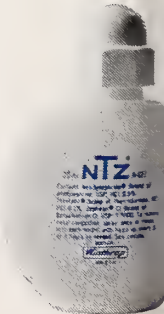
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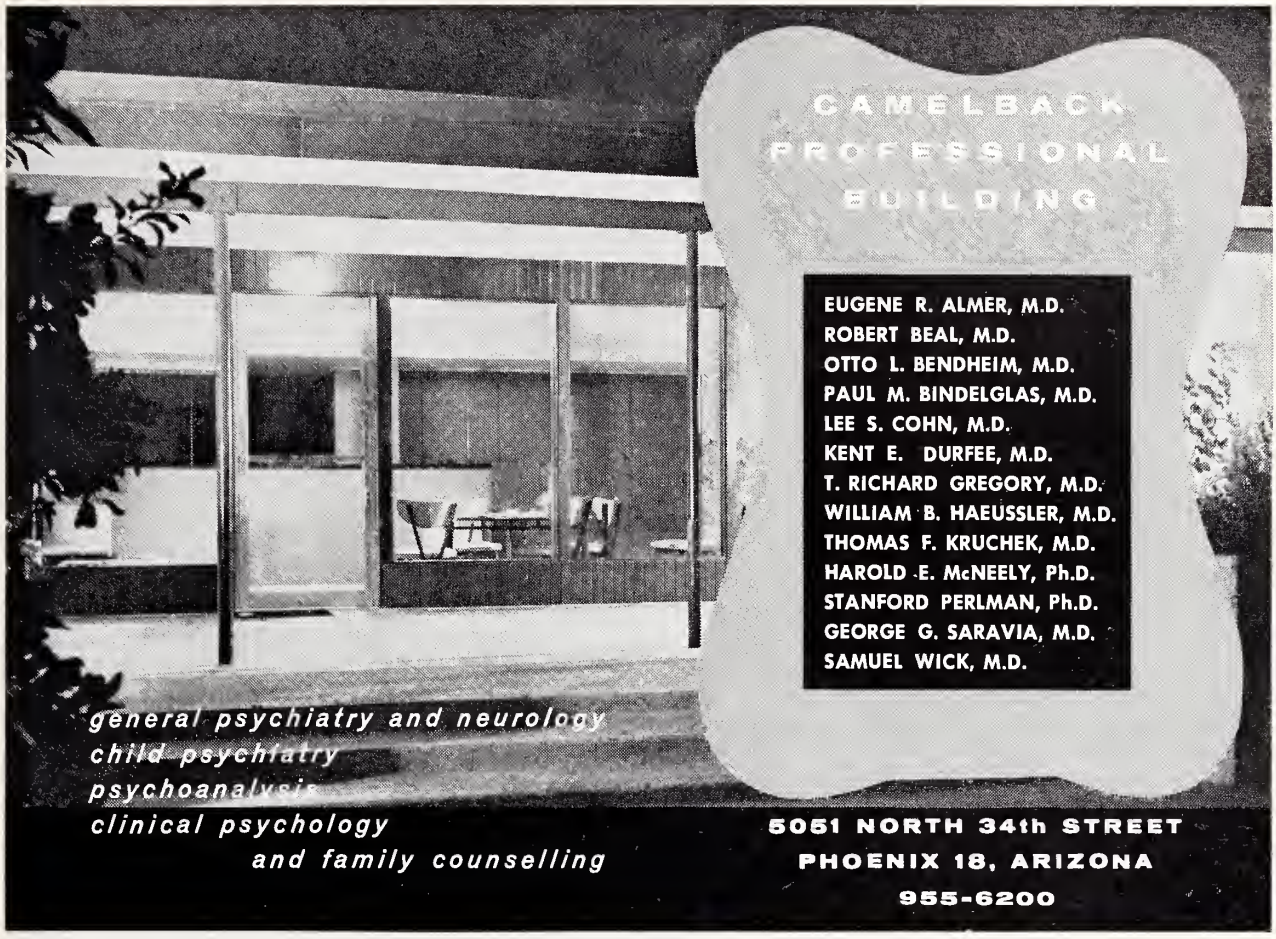
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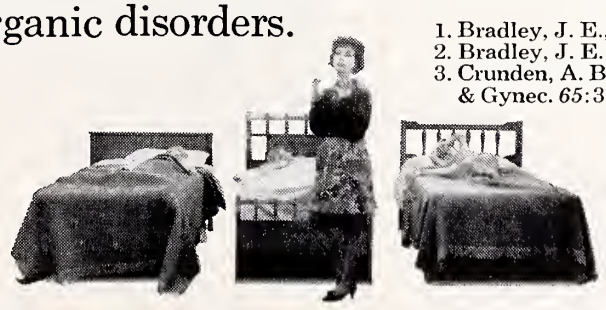




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2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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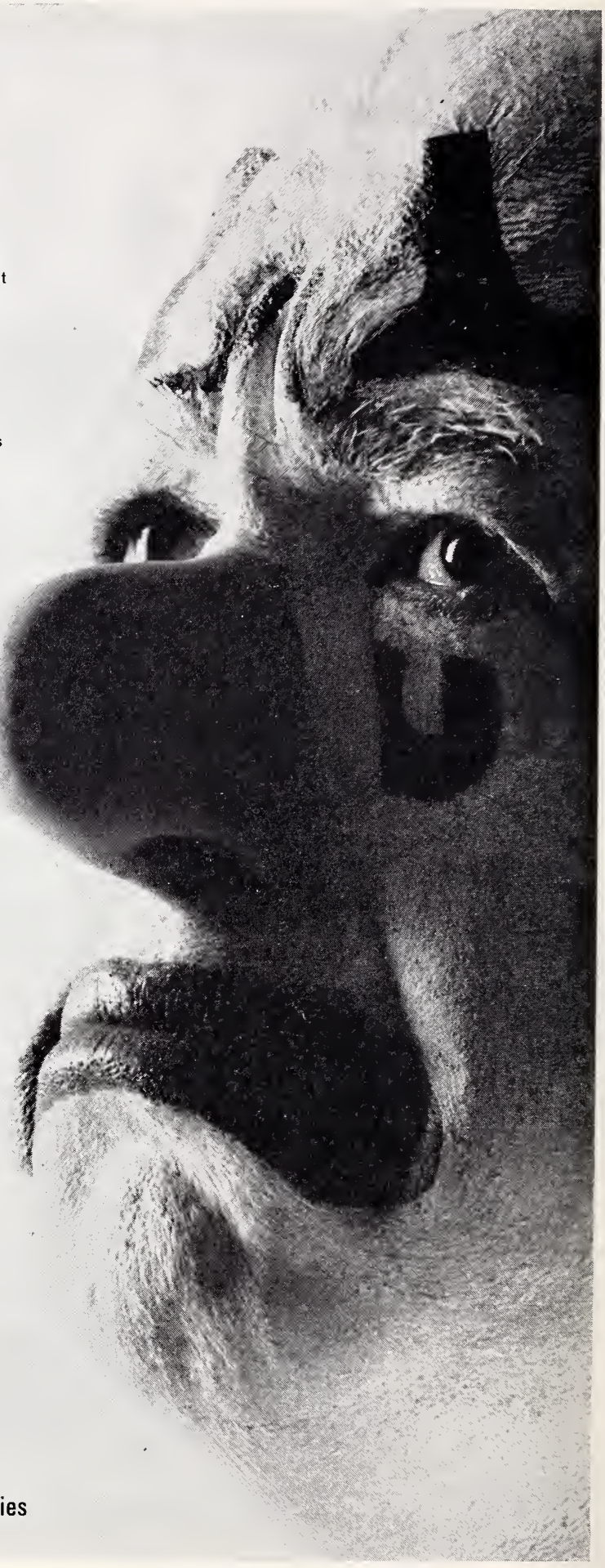
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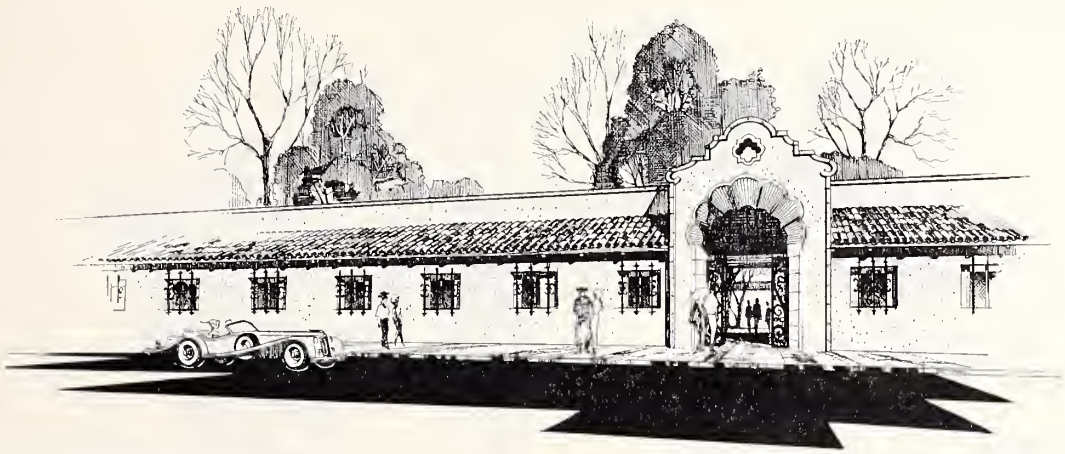
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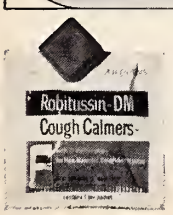
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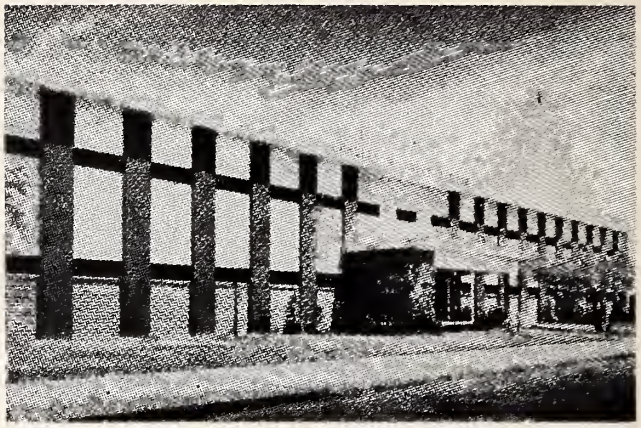
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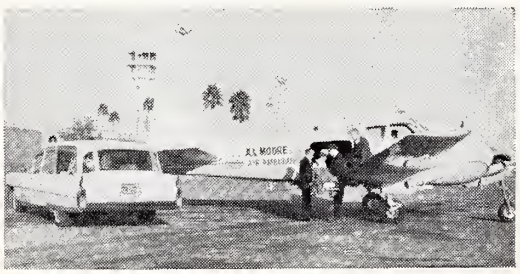
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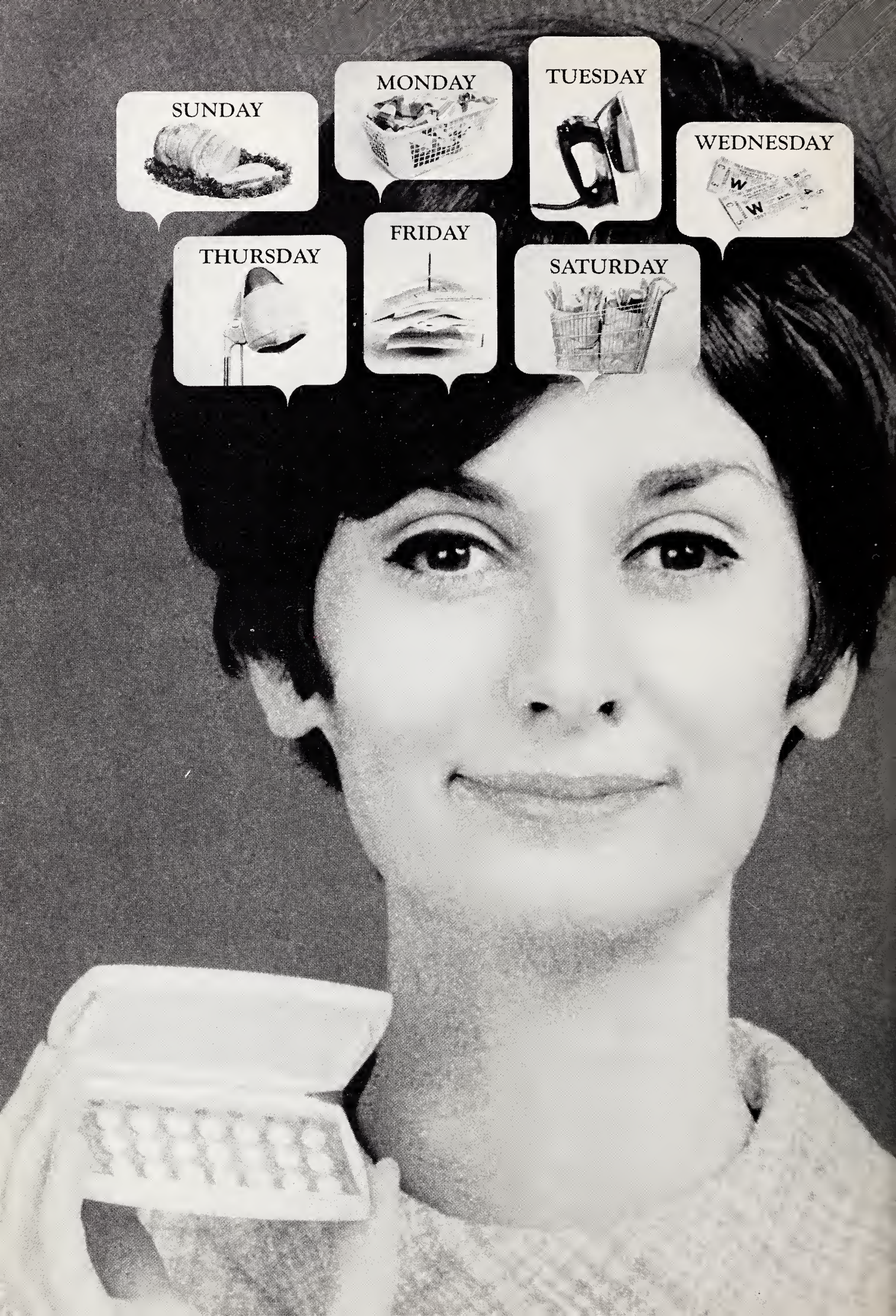
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ARIZONA MEDICINE

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind.

BENYLIN EXPECTORANT helps break down tenacious mucous secretions... tends to inhibit cough reflex... soothes irritated throat membranes... reduces congestion in the bronchial tree. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

41068

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

- LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.
- Literature on indications and dosage available on request.
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- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

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(LTR23)

WHAT SHOULD A DOCTOR'S FEE BE?

Recently we had a plumber at our house — he charged for his labor $14.00 for a half hour.

Add up the years of time, study, labor and investment made in liberal arts, medical college, internship, and possibly even time waiting to build up a practice. All of these costs should be applied against the productive years.

The dollar today is a 40-cent dollar compared to the dollar in the 40's. Even if we take the last 10 years the dollar has shrunk in value 16 cents. So apply inflation to the doctor's fee.

Deduct for high rent, office expenses and personnel. Deduct for depreciation on equipment.

Deduct for costs and time involved in government Medicare and other paper work, accounting, collecting.

These reductions and comparisons put doctors' fees in the right perspective.

How can the doctor protect his earnings? How can he protect his savings against the ravages of inflation?

When the Page Land & Cattle Co., which is an old institution in Arizona dating back to 1910, has investment potentials available for investors we customarily handle them.

The U.S. Supreme Court has stated that one may avoid though he may not evade a tax.

Breeding herds permit current deductions and ultimately capital gains on sales.

In many situations doctors are prepaying interest.

Persons who have gotten lands from Page Land & Cattle Co. have generally done well — capital gains-wise.

Protect your hard earned dollars. Give us a call or send us a card and we will meet with you at your convenience at your office or your home.

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NOVEMBER 1968/VOL. 25 NO 11

ARIZONA MEDICINE

JOURNAL OF ARIZONA MEDICAL ASSOCIATION • MEDICAL SOCIETY OF THE UNITED STATES AND MEXICO

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ON THE COVER

This month's cover is through the courtesy of the many doctors sitting in many meetings whose hands must be busy doodling while their minds are busy dealing with the myriad of Association problems.

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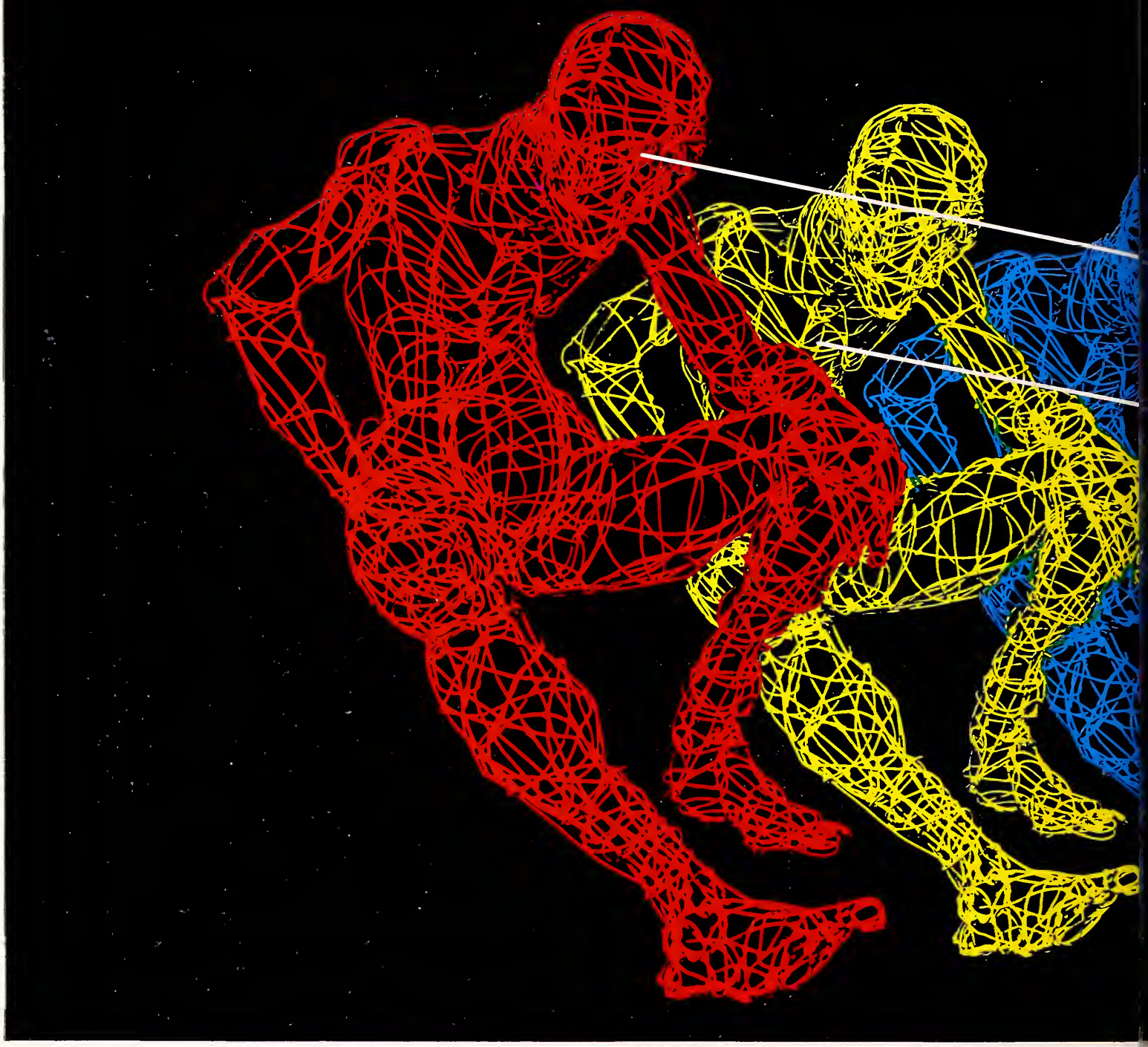
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a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

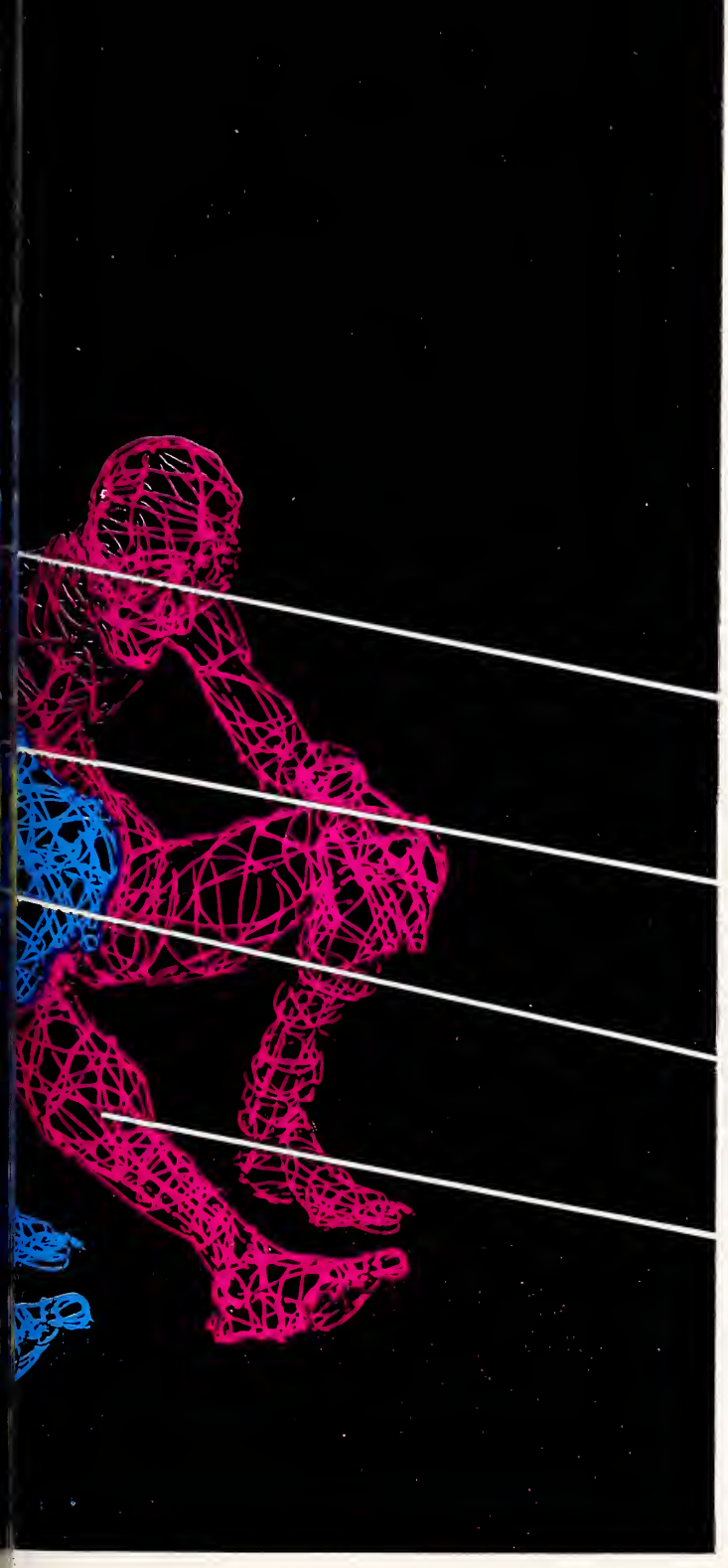
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropria investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequa vitamin B_{12} therapy may result in hematologic remission but ne rological progression. Adequate doses of vitamin B_{12} (parenter or oral with potent intrinsic factor as in Trinsicon® [hematin concentrate with intrinsic factor, Lilly]) usually prevent, halt, improve the neurological changes.

As with all preparations containing intrinsic factor, resistan may develop in some cases of pernicious anemia to the potenti tion of absorption of physiological doses of vitamin B_{12}. If resis ance occurs, parenteral therapy, or oral therapy with so-calle massive doses of vitamin B_{12}, may be necessary. No single re men fits all cases, and the status of the patient observed follow-up is the final criterion for adequacy of therapy. Period



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

nical and laboratory studies are considered essential and are commended.

lverse Reactions: In rare instances, iron in therapeutic doses oduces gastro-intestinal reactions, such as diarrhea or constiation. Reducing the dose and administering it with meals will nimize these effects.

In extremely rare instances, skin rash suggesting allergy has llowed oral administration of liver-stomach material. Instances apparent allergic sensitization have also been reported after al administration of folic acid.

sage: One Pulvule twice a day. (Two Pulvules daily produce a ndard response in the average uncomplicated case of pernious anemia.)

w Supplied: Pulvules Trinsicon® (hematinic concentrate with rinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

801668

Lilly



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

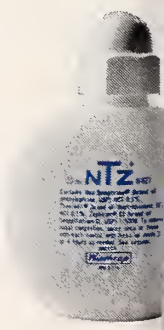
Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthr

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Editor's Page

DUES

	1955	1968
1 Loaf bread	$ 0.25	$ 0.39
1 Lb. butter	.59	.89
1 Pkg. cigarettes	.15	.40
1 G.P. office call	4.00	6.00
1 G.P. night call (E.R.) ..	5.00	15.00
1 ArMA Annual Dues ..	60.00	105.00
1 ArMA Total Budget ..	36,520.00	204,375.00

Over the past three years at least one letter per month reaching our desk dealt either directly or indirectly with a raise in the dues of the Arizona Medical Association either in the past, present or future.

Each year my intimate colleagues grumble about the levies of both the State Medical Association and the American Medical Association, yet one particular County Society initiated and passed several years ago an annual levy of $15.00 per member to furnish monthly dinners for members attending the County Medical Society Meeting at which thirty per cent attendance is a huge gathering.

Nobody minded. Yet the objections to a raise in the cost of our Annual Meeting in 1968 were loud and vociferous. That meeting broke all existing attendance records for this annual affair.

We will spend $10.00 per person on a good dinner and indulge ourselves as often as possible. Yet we will resist even the consideration of a raise in dues and relegate it to a position of non-discussion most often reserved for family skeletons.

Why?

No dues increase is being planned, proposed, or to the best of my knowledge even being contemplated, but I wonder "Why not?" We want the best from our personal pleasures — why settle for less in our professional desires?

In this life one gets exactly what he pays for. The least we can do in our medical community is go FIRST CLASS.

For more information on your Association read the article on page 988.

Roland F. Schoen, M.D.
Editor



No one should be cold on a Caribbean cruise

To those with peripheral vascular disease, a balmy ocean breeze can become a limb-chilling wind . . . a stroll on the deck a painful, stop-and-go chore.

Priscoline can help. It dilates peripheral blood vessels, increases blood flow to extremities. Relieves numbness. Makes hands and feet less prone to chill. Makes patients more comfortable. Helps them get around.

Nothing magic about Priscoline. But people with peripheral vascular disease might think so.

See following page for prescribing information.

Priscoline®

(tolazoline)
peripheral vasodilator

CIBA

2/3851

Priscoline®
hydrochloride
(tolazoline hydrochloride)



Indicotions Spastic peripheral vascular disorders.

Precoutions Tolazoline stimulates gastric activity and increases hydrochloric acid content of the stomach; use cautiously in patients with gastritis or peptic ulcer or in those with suspected peptic ulcer. Give cautiously, if at all, to patients with known or suspected coronary artery disease.

Adverse Reoctions Occasional: nausea, epigastric discomfort, tachycardia, flushing, slight rise or fall in blood pressure, increased pilomotor activity with tingling or chilliness. Rare: vomiting, diarrhea. Symptoms are generally mild and frequently disappear with continued therapy, regardless of dosage.

Administrotion ond Dosage Careful individualization of dosage is required.

Oral *Tablets*: Usually 25 mg 4 to 6 times daily is sufficient. If necessary, dosage may be increased gradually up to 50 mg 6 times daily.

Lantabs: Generally, 1 Lontab every 12 hours will achieve the same effect as one 25-mg regular tablet every 4 hours (6 times a day). Thus, continuous action throughout the night is achieved without the need for arising to take additional medication.

Parenteral *Subcutaneously, Intramuscularly, or Intravenously*: 10 to 50 mg 4 times daily. Start with low doses, increasing with patient under close observation until optimal dosage (as determined by appearance of flushing) is established. Keeping patient warm will often increase effectiveness of drug.

Supplied *Tablets*, 25 mg (white, scored); bottles of 100 and 1000. *Lantabs*, 80 mg (bright yellow); bottles of 100. *Multiple-dose Vials*, 10 ml, each ml containing 25 mg tolazoline hydrochloride, 0.65% sodium citrate, 0.65% tartaric acid, and 0.5% chlorobutanol as preservative in water; cartons of 1.

Lontobs® (long-acting tablets CIBA)

Consult complete literature before prescribing. 2/3851

CIBA Pharmaceutical Company, Summit, N.J. CIBA

Easy on the Budget... Easy on the Mother

Tablets & Elixir

For Iron Deficiency Anemia

FAMOUS **Fergon®**

brand of FERROUS GLUCONATE

BREON

BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

See next page for prescribing information



You've made it one of your specifics in acute bronchitis

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specifics in acute bronchitis

Your experience has shown that H. influenzae and D. pneumoniae are commonly implicated in acute bronchitis. And DECLOMYCIN is effective against these organisms. Although some strains may resist its action, and other organisms may also be involved, sensitivity testing will prove the usefulness of DECLOMYCIN.

You know, too, that DECLOMYCIN provides rapid, high and prolonged activity levels in both serum and tissue.

Dosage is convenient—300 mg b.i.d. or 150 mg q.i.d.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—Anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg. q.i.d. or 300 mg. b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg.; **Tablets:** film coated, 300 mg., 150 mg. and 75 mg. of demethylchlortetracycline HCl. 393-8

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

Lederle

Next step after a thiazide

Serpasil®-Esidrix®

#2 Tablets: 0.1 mg reserpine and 50 mg hydrochlorothiazide
#1 Tablets: 0.1 mg reserpine and 25 mg hydrochlorothiazide

CIBA Pharmaceutical Company, Summit, N.J.
2/3819

CIBA


Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

Tandearil, oxyphenbutazone:
For brief summary see next page.

Geigy

TA-6006



Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502



Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done . . . in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A·H·ROBINS

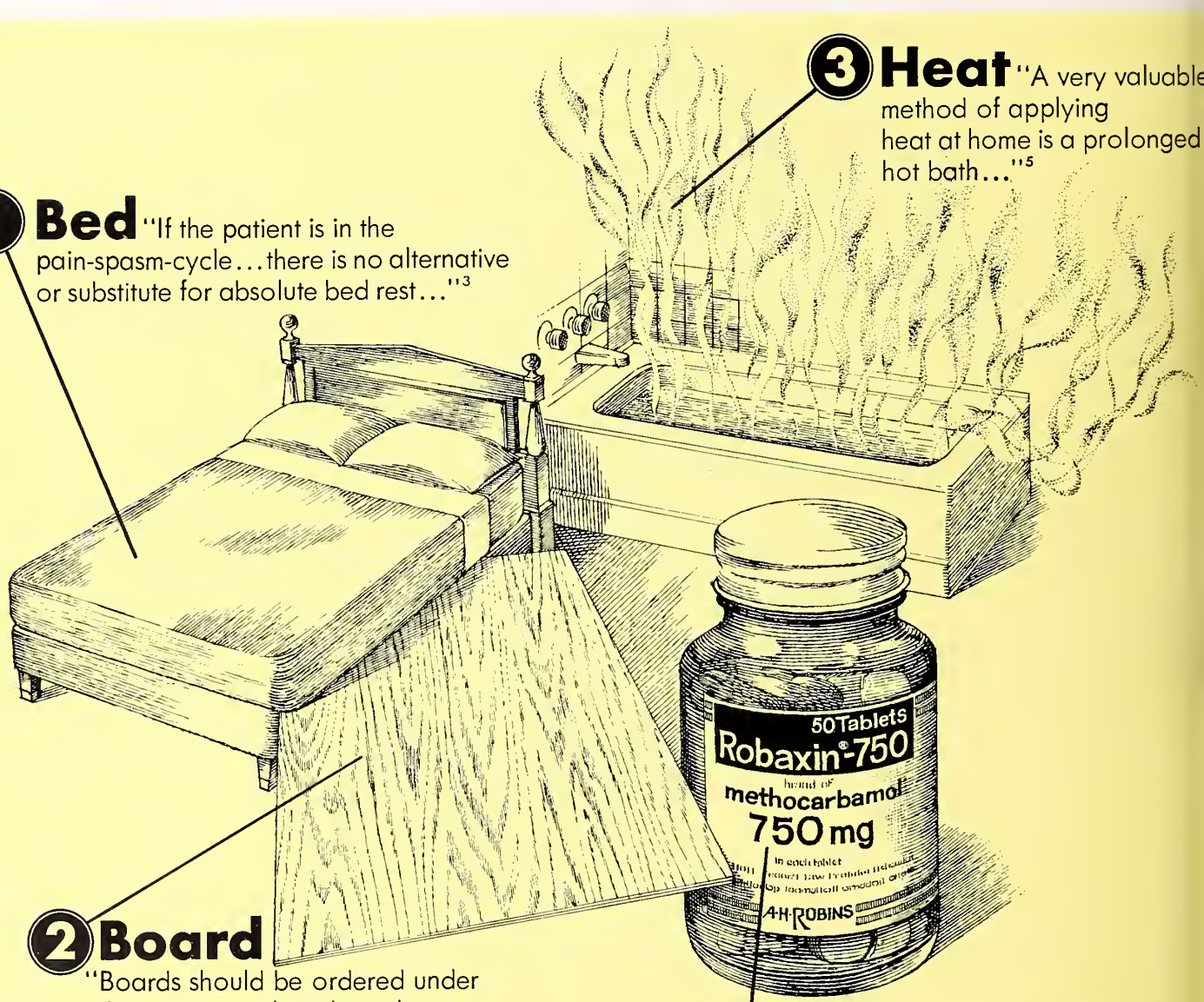
in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®
(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)
up to 10-12 hours clear breathing on one tablet



LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

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References: (1). Gadfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gattschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: Sauth Dakata J. Med. 18:26, 1965. (5). Sata-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteapath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New Yark J. Med. 62:1985, 1962.

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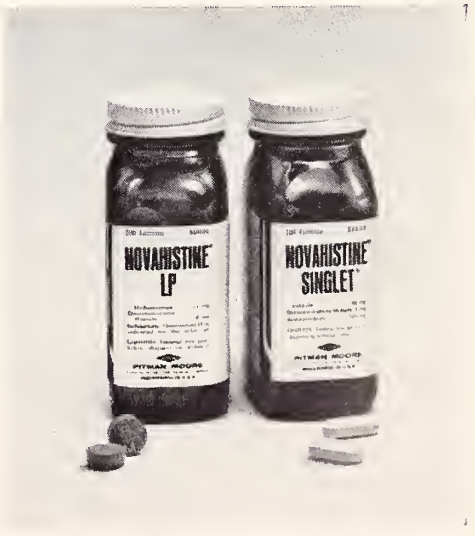
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ArMA Reports

GOVERNING BOARD ARIZONA MEDICAL ASSOCIATION HISTORICAL COLLECTION

Meeting of the Governing Board of the Arizona Medical Assoeiation Historieal Colleetion held August 14, 1968, at the College of Medieine.

PRESENT: Drs. DuVal, Merlin K., Dean, College of Medieine; Meliek, Dermont W.; Sehoen, Roland F., Chairman, History and Obituaries Committee, ArMA. Messrs. Bishop, David, Librarian, College of Medieine; Gilehriese, John D., Field Historian, U of A; Robinson, Bruee E., Assistant Exeeutive Seeretary, ArMA.

Meeting was called to order by Dr. Sehoen. There was no old business.

NEW BUSINESS

First to be considered was the definition of the exact reeipient of any gifts of an historieal nature and of a medical nature to the University of Arizona. The following was deeided:

1. The University of Arizona College of Medicine will be the reeipient of any and all gifts.
 (a) The Librarian of the University of Arizona College of Medieine, Mr. David Bishop, will write a letter of acknowledgement and reeeipt of the material.
 (b) The material will be inventoried and disbursed jointly by Mr. David Bishop and Mr. John Gilehriese, with the storage of various items being arranged and deeided between themselves.
 (e) The responsibility of final storage of any items shall be the problem speeifically of the University of Arizona.
2. The University of Arizona College of Medicine will develop an operational procedure for the use of donated gifts. This operational proeedure will be presented at the earliest possible time to the Board of Direetors of The Arizona Medieal Assoeiation, Inc., for information and aceeptanee.
3. The Arizona Medieal Assoeiation, Ine., through any of its eommunieation branehes, will be the distributing agent for information relative to this historieal projeet.
 (a) Any information will be eleared kindly between Mr. David Bishop and Mr. Bruee E. Robinson, and it is understood that any of the existing media of eommunieation may be used.

It was suggested that a portion of the $10,000.00 whieh has been designated for the use of the University of Arizona College of Medieine be made available for the historieal projeet. Final deeision on this is deferred until more definite plans for its use ean be drafted.

There being no further business, the meeting was adjourned.

Roland F. Sehoen, M.D., Chairman
History and Obituaries Committee

BOARD OF DIRECTORS

Meeting of the Board of Direetors of the Arizona Medieal Association, Inc., held Sunday, September 8, 1968, in the Convention Center of the Safari Hotel, Seottsdale, Arizona, eonvened at 10:04 A.M., Fred H. Landeen, M.D., Viee President and Chairman, presiding.

ROLL CALL

PRESENT: Drs. Beckwith, Harry S.; Brooks, Jack E.; Czerny, Everett W.; Dew, Philip E., Treasurer; Dudley, Jr., Arthur V., President; Dysterheft, Arnold H., Past President; Finke, Howard W.; Flynn, Richard O., President-Eleet; Grobe, James L.; Heileman, John P., Secretary; Henderson, Charles E.; Jarrett, Paul B.; Landeen, Fred H., Viee President Rhu, Jr., Hermann S.; Sattenspiel, Edward; Seott, William C.; Shapiro, Seymour I.; Standifer, John J.

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Guests: Drs. DuVal, Merlin K., Dean, College of Medieine, University of Arizona; Ritter, Edward L., President, Yavapai County Medieal Soeiety; Wilson, John A., President, Pima County Medieal Society.

Messrs. Brown, W. J., AMA Field Representative; Kelly, Frank, Appraiser; Martin, Charles J., VNB Investment Offieer.

EXCUSED: Drs. Cloud, Daniel T.; Moody, Deward G.; Priee, Robert A.; Sehoen, Roland F.; Steen, William B.; Young, Woodson C.

Mr. Jaeobson, Edward, Counsel.

WELCOME

A quorum being present, Dr. Landeen ealled the meeting to order extending a cordial weleome to the guests in attendanee.

MINUTES

Approved minutes of the meeting of the Board of Direetors of this Assoeiation held July 14, 1968.

HOUSE RESOLUTION NO. 6-65

House Resolution No. 6, adopted, as amended, May 1, 1965, gave $10,000.00 to the College of Medieine of the University of Arizona, said funds to be deposited by the Board of Direetors into a separate interest-bearing trust aeeount and disbursed only by the Board of Direetors for a designated purpose, as determined by the Board of Directors in joint conferenee with the Dean of the College of Medieine. The interest earned to date has been deposited in the "Scholarship Fund" aeeount and used for that purpose. To further earry out the intent of this resolution, Dr. Merlin K. DuVal, Dean of the College of Medieine of the University of Arizona, was invited to attend this meeting and, in joint eonferenee, determine disbursement for a designated purpose.

Dr. DuVal stated this contribution should be treated as a joint project — a joint deeision should be made as regards how best to use it. There are two basieally different ways in whieh the funds eould be used: one obviously is to use the prineipal either as a single shot investment to aeeomplish a specific purpose, or to use that same prineipal gradually, perhaps, to aeeomplish several purposes; and two, to use the ineome so that the prineipal remains intaet forever. Obviously, there would be eertain restraints upon either route. The amount of

money, for example, would be quite different than that which is available if you use only the interest.

Now, in terms of how to use it, Dr. DuVal suggested that there are three general categories of use of funds of this kind. The first category: (a) would benefit the student directly such as with prizes, books, scholarships, loans, summer work stipends, this type of thing; (b) would benefit him through some educational device or instrument such as sending him out of the state, even out of the country if he was a particularly acceptable person, for a preceptorship or an out-of-state or foreign experience; (c) or support some kind of a visiting lecturer to give to the campus and take up residency there for a short while, a visiting professor type thing. The second category would be uses to benefit the faculty in general — this might be a travel fund to help faculty persons to get to certain scientific meetings; assist in their research efforts; or it might be certain faculty prizes. The third category, the school more generally could use funds or gifts of this kind for building or capital purposes; as discretionary funds to bind and patch wounds, to mend fences, to plug holes, the kind of things you cannot do out of the budget, it could be used to support the purchase of teaching equipment, audio-visual materials, this kind of thing; something in and around the library such as exhibits or books, services, perhaps, copying services for physicians of the state, these kinds of things; to support historical collections; it could be used to support animal work, in other words, not clearly tied specifically to a faculty or student body. This list, of course, is not at all exhaustive, it is to give you an idea of the way that we would probably use gifts of this general category, except for extremely large ones, and then, I would suggest that whatever we collectively decide to do between the State Medical Association and the Medical School, it would be my personal, strong preference that the gift clearly be identified as a gift from the State Medical Association and I would prefer, personally, that it would be used with the capital invested and not lost and have the gift come from the earned income so that it would be perpetual, it will still be there one hundred years from now for that matter if it has served our purpose well, and if you want to enlarge the principal you could do that — a gift in perpetuity. That's a brief summary then as the way I would like it, said Dr. DuVal, thanks and I would welcome any comments.

In answer to a question, Dr. DuVal further stated that his preference would be that the principal be left intact, invested, and that the earnings from that be available to accomplish one of two things, both directed toward the benefit of the student as an educational additive, if that's the right word. I would suggest that we pick out a student either once a year from say the senior class and support him for a clerkship or something out of the state, or even every two years; perhaps pick the best student between the junior and senior classes and send him overseas for a three-month experience, or something like this. It would take two years, obviously, at 5% on $10,000.00. This is the point I had in mind here. It would be a fantastic experience for the student and it would give them all something to shoot for and aspire for. It could be considered in the nature of a prize in the sense that it is earned competitively and we could set up any kind of a judgment system to select the winner, but it would make it possible for a single student to come back and bring some of his experiences with him to the rest of the class, etc., and I just think this is not the kind of thing you can do, out-of-state or otherwise, with budgeted funds, and it would add a perfectly remarkable dimension to the experience of the school. My second choice would be to do things in reverse by having some prominent person from somewhere else in the country, or even in the world, to come to the campus for appropriate lectures or visit of several days or whatever the funds will support. Those would be the highest priority on my list.

Preference was expressed to benefit the student.

It was regularly moved and unanimously carried that the funds be used to further student education, as outlined by Dr. DuVal.

ArMPAC BOARD OF DIRECTORS

In the absence of John F. Kahle, M.D., Chairman of the Board of Directors of ArMPAC, Dr. Richard O. Flynn, President-Elect, reported in his behalf that to date a total of 630 members have joined the ArMPAC organization. It is planned to release another "call" for membership in early September.

It was regularly moved and unanimously carried that Dr. Chauncey D. Buster (Yuma), Dr. William W. McKinley, Jr. (Bisbee), Mrs. Robert J. Oliver (Tucson), and Mrs. Lewis S. Winter (Phoenix) be appointed members of the ArMPAC Board of Directors for the term 1968-69.

Fred H. Landeen, M.D., Vice President, declined appointment because of his official position with the ArMA Board of Directors. All members appointed to the ArMPAC Board by the ArMA Board of Directors in meeting held July 14, 1968, accepted the assignment.

BOARD OF DIRECTORS

ArMA Officer Honorarium — Resolution

John J. Standifer, M.D., as secretary of the Mohave County Medical Society presented the following resolution for the consideration of the Board:

> Payment of an annual honorarium including the President ($5,000); the President-Elect ($3,000); the Vice President ($3,000); the Secretary ($3,000); and the Treasurer ($3,000).

Considerable discussion ensued. It was stated that with the office go certain financial obligations and responsibilities. While certainly these officers should be reimbursed for certain expenditures including travel mileage and actual expenses in instances where an overnight stay is requisite when the officer is on official business representing this Association within and without the state, the payment of an honorarium was not favored at this time if for no other reason than the Association cannot presently afford it.

It was regularly moved and seconded that this resolution be tabled. The motion carried, Dr. Flynn voting in the negative.

BOMEX — Compensation

Counsel reported on the proposed amendment to the Medicine and Surgery Act, Chapter 13, § 32-1402F., A.R.S. providing that members of the Board of Medical Examiners shall receive $100 for each day of actual service (rather than the $25 now provided). It was concluded that on the basis of information in hand the

possibility of enactment of such proposed amendment did not appear favorable at this time; therefore, it was recommended that such amendment not be submitted. RECEIVED.

Arizona Medical Association Foundation

It was reported that the Internal Revenue Service approved federal income tax exemption 501(c) (3) Internal Revenue Code requiring annual accounting December 31st of each year, associate with the recently established Arizona Medical Association Foundation.

It was reported that Counsel for Mrs. Marie B. Mallory of Wickenburg, Mr. Alvin E. Larson, has suggested to Mrs. Mallory that a codicil to her will executed April 5, 1968, be executed providing for the bequest to be paid to the Foundation rather than the Arizona Medical Association.

Mr. Jack Brown, AMA Field Representative, reported that AMA has prepared a plaque to be presented to Mrs. Mallory expressing appreciation for that portion of the bequest designated to go to the American Medical Association Education and Research Foundation used for medical student loans. It is planned to join AMA for an appropriate presentation to Mrs. Mallory just as soon as the codicil has been executed.

Maricopa County Medical Society — Nominations

In recognition of the request of Maricopa County Medical Society, it was agreed that component county medical societies will be consulted in the future when feasible and given the opportunity to present nominations in instances of appointment of members of a society to State and National Organizations which are made from time to time by the ArMA Board of Directors, prior to such appointment.

BENEVOLENT AND LOAN FUND COMMITTEE

Scholarship Awards

Reaffirmed the granting of scholarship awards in the sum of $500 each to the following:

Barker, George Thomas (Phoenix): Graduate ASU
To Attend University of Arizona College of Medicine — Acknowledgement

Bowe, Patricia Ann (Tempe): Graduate ASU
To Attend University of Arizona College of Medicine

Francis, David John (Tucson): Graduate University of Arizona
To Attend Yale University School of Medicine — Acknowledgment

Jones, William Guy (Phoenix): Graduate Loma Linda University
To Attend Loma Linda University School of Medicine — Acknowledgment

Temple, James Terry (Prescott): Graduate University of Arizona
To Attend University of Arizona College of Medicine — Acknowledgment

Weaver, Michael Joseph (Tucson): Graduate University of Arizona
To Attend University of Arizona College of Medicine — Acknowledgement

Wesolowski, David (Phoenix): Graduate University of Arizona
To Attend University of Arizona College of Medicine — Acknowledgement

Mallory Medical Student Scholarship Fund — Establishment

The establishment of a "Mallory Medical Student Scholarship Fund" was discussed. It was determined that this matter be referred back to the Benevolent and Loan Fund Committee with the request that it give consideration to what would be most appropriate to honor those people who so graciously bequeath monies to the Arizona Medical Association Foundation for scholarship or other purposes.

AD HOC BUILDING COMMITTEE

Dr. Dudley briefly reviewed events to date referable to the proposed Building Program. The report included a resumé of meeting called by Maricopa County Medical Society and held at the Smokehouse, Phoenix, Thursday, September 5, 1968.

Property on West Bethany Home Road was discussed and Mr. Frank Kelly gave his opinion from an Appraiser's standpoint. Currently the area is zoned R-3. To accommodate the needs of the Association this zoning should be changed to R-5 (office buildings). The square foot property area, parking, building costs, etc., were analyzed.

He recommended purchase of property providing the zoning change from R-3 to R-5 is accomplished; the square foot area (200' x 200') is assured; that all essential utilities are available including paving, etc., and that there are no outstanding assessments of record against the property; and so forth.

It was regularly moved and carried that this Association proceed to purchase the West Bethany Home Road property, subject to the conditions as outlined by Mr. Kelly, at a cost of $30,000 (75c per square foot).

Safari Building Lease

The Executive Committee conferred with Mr. Russell D. Gribbon, manager of the Safari Hotel, owners of the Safari Building presently occupied as the Central Office headquarters of this Association. The committee laid before him plans of the Association relating to its proposed building program. The current five year lease expires July 31, 1969. It provides for a renewal of five years at a 10% increase in rental subject to any revision account tax increases. While, of course, Management would hope that the Association would continue to be a tenant of the Safari, under these circumstances, it would be understandable that the properties now available would no longer be needed at some given time. Mr. Gribbon was asked whether or not the Safari would be agreeable to an extension of lease for a term of one year from August 1, 1969. His reaction to this inquiry indicated that he saw no problem so long as management knew in advance the program of the Association. Steps will be taken to realize an extension of the current lease for a term of one year. REPORT RECEIVED.

Assessment Notice

It was regularly moved and unanimously carried that the "assessment notice" as authorized by house resolution No. 6 adopted April 27, 1968, providing for a special assessment of $125 per member on a single payment basis or allowed to be payable on a $15 per year basis for ten years; and that all members henceforth be required to pay this special assessment at the same rate of $125 as a single payment or on a basis of $15 per

year for ten years to allow members to have an equal part in the owning and operation of our central office, be prepared and released on or about October 1, 1968, the notice to include as much information as possible relating to the program and proposed property purchase for the enlightenment of the membership.

EXECUTIVE COMMITTEE

Membership Classification Changes

Apache

Jerry T. Clifton, M.D. (Show Low — now Los Angeles) — Granted Associate membership (dues exempt) account Residency Training effective January 1, 1968.

Graham

Jack L. Bennett, M.D. (Safford) — Granted Associate membership (dues exempt) account Residency Training, effective September 1, 1968.

Maricopa

Marie H. Bohn, M.D. (Phoenix) (NEW) — Granted Service (¼ Dues) account full-time employment Arizona State Hospital, effective September 5, 1968.

James E. Lett, M.D. (Phoenix) (NEW) — Granted Affiliate (dues exempt) account full-time employment as Medical Education Director, Good Samaritan Hospital, Phoenix, effective June 26, 1968.

Ray Lewis, M.D. (Phoenix) (NEW) — Granted Service (¼ Dues) account full-time employment as Director of the Division of Mental Health of the Arizona State Department of Health, effective January 1, 1968.

Lucy S. Hernried, M.D. (Phoenix)—Granted Associate (dues exempt) account Residency Training, effective July 1, 1968. Dues Refund Requests: ½ ($52.50) July 1, 1968 (1968 Dues Paid in Full February 2, 1968).

ArMA Funds Investment

At the present time ArMA Funds appropriated or unappropriated, not required to meet immediate operational expenses, are distributed in a number of Arizona banks in savings accounts drawing interest. Several weeks ago the Valley National Bank was requested to review our situation and offer comment or recommendation as to how we might better administer these savings. Mr. Charles J. Martin, investment officer of VNB, was assigned the task of review and is here this morning to report.

Mr. Martin reviewed the accounting furnished him by the Central Office covering the year 1967 and the first six months of 1968. He presented a table setting forth the possibility of investment commencing with the first quarter of a year and an amount of $100,000 which could be invested in 90-day Certificates of Deposit or Treasury Bills or Commercial Paper depending on rates. During the second quarter a reinvestment of $60,000 of this money from the maturing paper first referred to could could be made in the same fashion; in the third quarter reinvest $35,000 of the maturing $60,000; and in the fourth quarter there would be no reinvestment of these monies (principally dues receipts) as the balance of funds are needed to cover operational expenses. There is an additional sum of money approximating $90,000 referred to as "reserve" presently in savings accounts that could be used to better advantage by investing in 30-day Treasury Bills or Commercial Paper. As the funds mature every thirty days they may be "rolled over" for an additional 30-day period. In the event funds are needed for unexpected expenses this plan will provide them within a 30-day period. Currently Commercial Paper provides the most attractive return at a rate of 5⅝% for the 30-day maturity. If funds are invested as outlined today that would produce earnings approximating $7,804.68.

Commercial Paper is an unsecured promissory note issued directly by companies or through dealers. Some of the companies include General Motors Acceptance Corp., Sears Roebuck Acceptance Corp., General Electric Credit Corp., and Ford Motor Credit Corp. The notes are usually issued for a period of from 5 to 270 days on a discount basis but on request can be issued as interest-bearing at a coupon equivalent of the quoted discount rate. Prime issuers must be readily recognizable as having an excellent credit standing based on the company's financial position and earning power. In addition, since the companies carry lines of credit with leading banks, there are regular and continuous credit reviews being made by these banks. Considerable diseussion ensued.

It was estimated that such investment program would nealize for the Association an additional income of between $2,000 and $2,500 per annum. Mr. Martin advised that there is no charge for this service.

It was regularly moved and unanimously carried that the Treasurer be permitted to invest the funds of the Association in the manner as described (by Mr. Charles J. Martin, Investment Officer of VNB) and to take whatever other action is necessary (to implement this investment program).

Officers and Staff Meeting Expenses

Accepted the recommendation of the Executive Committee that the $40 per diem maximum be removed as relates to the payment of expenses to officers and staff designated to attend meetings on official Association business and in lieu thereof it be determined to pay actual expenses incurred, without honorarium, in addition to first class jet air transportation.

GOVERNMENTAL SERVICES COMMITTEE

Title XIX Demonstration Project

The Governmental Services Committee in meeting held July 21, 1968, recommended to the Board of Directors that active publicity be sought to make known to the general public the attitude of the Association, and our vigorous efforts to establish the Title XIX Demonstration Project for the Pima County area, and why the project was not adoptcd by thc State Welfare Commission. It was reported that considerable discussion in this regard during the Executive Committee meeting held yesterday opened discussion relating to the implementation of Title XIX by the Arizona Legislature. It was stated that the Governor was opposed to the undertaking of the Pima Demonstration Project because of its potential eost which might involve other areas in the state; likewise, it might hasten the implementation of the Title XIX Program which is of serious economic concern to Arizona in that there can be no discrimination thereby making available to the entire indigent Indian population, which is considerable, the benefits. It is felt that Arizona can ill afford this substantial increased load

which has been the past responsibility of the federal government. It was determined to take no action in regard to the Pima Demonstration Project at this time.

It was regularly moved and unanimously carried that the ArMA through its Board of Directors reaffirms the Association's position in support of Title XIX (implementation).

Medicare Part B — Medical Review Committees

The Governmental Services Committee in meeting held July 21, 1968, on request of the carrier, Aetna Life and Casualty, determined to consolidate its six Medical Review Committees (organized to adjudicate Medicare claims) into two such committees, one representing the Northern areas (including Central, Northeastern and Northwestern Districts) and the other representing the Southern areas (including Southern, Southeastern and Southwestern districts). Following due deliberation yesterday it is the recommendation of the Executive Committee that because of the minimal number of claims presented for adjudication that the Governmental Services Committee be selected and appointed to assume the function of a Medical Review Committee; further, that Woodrow W. Scott, M.D. of Tempe be appointed a member of the Governmental Services Committee for a term of three years, Dr. Scott having been recently appointed by Aetna as its Medical Advisor in the settlement of Medicare claims.

It was regularly moved and unanimously carried that the recommendation of the Executive Committee be accepted, i.e. that we have one Medical Review Committee and that that Review Committee be the Governmental Services Committee; that those members previously appointed or to be recommended appointed to serve the suggested consolidated Northern and Southern District Medical Review Committees be dismissed with an expression of grateful appreciation for their interest and willingness to serve; and that Woodrow W. Scott, M.D. (Tempe) be appointed a member of the Governmental Services Committee for a term of three years and that he be so notified.

GRIEVANCE COMMITTEE

Case No. 129

The Grievance Committee in meeting held August 3, 1968, reviewed Case No. 129 and interviewed both the complainant and defendant. Based upon those interviews and records submitted, it appeared to the Committee that the defendant is guilty of the complainant's charges of certain irregularities in certain billing procedures and the Committee believes said charges, if true, do constitute a wrong; further, that the Committee believes that the nature of the evidence is such that it should be turned over to the State Board of Medical Examiners for disposition, and the Committee believes it has the right to make its recommendation under the provision of Chapter VII, Section 4 (d) of the Association's By-Laws and particularly the alternative given to the Committee to "***recommend other appropriate action."

It was regularly moved and unanimously carried that the evidence in this Case No. 129 be turned over to the Board of Medical Examiners of the State of Arizona; and, as regards the other recommendations of the Grievance Committee, that it be asked to present to this Board a more specific recommendation as regards reprimand, censure or suspension, on advice of counsel.

INDUSTRIAL RELATIONS COMMITTEE

Cardiovascular Advisory Board

Reappointed Mayer Hyman, M.D. (Tucson), a member of the Cardiovascular Advisory Board to the Industrial Commission of Arizona for the term 1968-69. Dr. Hyman accepts the assignment.

Medical and Para-Medical Shortages

OTHER BUSINESS

Dr. Jarrett stated that in spite of the establishment and the projected establishment of new medical schools in this country, the future population faces a desperate shortage of physicians and para-medical personnel.

Some estimates put current shortage of physicians at 50,000 based on the current U.S. physician population of 315,868. Last year we graduated about 7,960 new physicians which was an increase of 217 over last year and 879 more than graduated in 1960. In spite of this physician increase, the population increase and increasing demand for medical services are making it ever more probable that the physician will have no time for personal pursuits, and ever more likely that he will fall into malpractice error.

The most serious aspect of the medical manpower situation is the fact that about a dozen of our medical schools are in danger of having to close. There are two reasons for this; first they have been in financial trouble for a long time and second, the cut in the Federal budget will further affect them. H.E.W. will probably get $650 to $950 million less than they had planned. In the fiscal year 1967, U.S. medical schools received $32.5 million in support of their educational activities and $135 million in construction grants. There has been some increase last year, but figures are not available as yet. The deans are in accord that this amount is woefully inadequate.

Should we lose 12 medical schools we would lose 1,000 new physicians yearly, nor would the 10 to 15 new medical schools on the drawing boards close the gap. These new schools were to augment the supply, and as you know it takes at least 10 years to get a new medical school into being and graduate its first M.D. The medical schools provide not only doctors, but other health professionals whom the schools train, technicians, nurses, physiotherapists and bio-chemists. The failure of a dozen medical schools might be prevented by the funds necessary to start a new medical school, and yet we need more medical colleges. The future cost of medical care depends on the law of supply and demand. With a physician shortage, a very high cost of physician services cannot be otherwise.

This Fall as an example of student tuition, Tufts University and the University of Chicago will charge their students $2,100.00 annually, and St. Louis University whose deficit has been running over one million a year, will also increase its $1,800.00 fee by $300.00.

Dr. LeRoy Levitt of the Chicago Medical School said in an interview, "We are importing 7,000 foreign doctors a year from nations who can ill afford their loss, while we turn away 6,000 to 7,000 young men and women from our country who are eminently qualified to become doctors." Chicago this year has 2,400 applications for only 75 openings.

It is apparent that tuition inereases alone can do little to stem the tide of increasing costs. The tuition covers at best a bare fifth of the cost. Medicine is becoming vastly more complex. Formerly, one or two physicians could teach internal medicine, for example. It now takes a large team of many specialists.

Recently, the AMA and the Association of American Medical Colleges in a joint statement expressed the need for medical schools to expand their enrollments in the face of a critical doctor shortage, and they called upon County and State Medieal Societies to form committees for the purpose of marshaling city, county and state action to increase the production of health manpower in both public and private institutions.

Dr. Robert C. Benson, Executive Director of the Association of American Medical Colleges, told a Senate subcommittee that last year, 8,540 foreign graduates entered the United States while only 7,743 physicians were graduated from American schools. Dr. William Stewart, Surgeon General of the Public Health Service, revealed that even if present plans to build 20 to 25 new medical schools by 1975 are fulfilled, the current physician-population ratio can be maintained only with the "continued licensing of about 1,600 foreign trained physicians a year."

You are painfully aware of the closing of the School of Dentistry of St. Louis University. It was an agonizing choice between the College of Dentistry and the College of Medicine.

When Dr. David Denker was installed as President of New York Medical College in 1967, he called on the nation's medical schools "to increase the total number of doctors by 100%." Medical Tribune commenting editorially said that, "doubling the nation's doctors may turn out to be a modest requirement." The total number of positions for interns and residents in this country's hospitals is to a considerable degree unfilled yearly.

At a time when our medical colleges are clearly seen to be a national resource and when "one university after another is finding it necessary to sever all financial arrangements with the medieal school because of the finaneial drain being far too severe for the University funds to bear any longer,' (according to Dr. Benson), and when one R.N. does her level but inadequate best to supervise the care on two floors, and when the demand for services increases monthly, it would be part of our obligation as an Association to do what we can to "marshal city, county and state action to increase the production of health manpower," and to make the public aware of the crisis and to let them know that something must be done and soon!

It was determined to refer this matter to the Professional Committee for review and study by its Section on Medical Edueation ultimately to report thereon to the Board of Directors through the Professional Committee with any recommendations indicated.

AMA Clinical Meeting — Miami Beach

Determined to send to the AMA Clinical Convention at Miami Beach, Florida, December next, at Association expense, the two Delegates, one Alternate Delegate (to be determined between the two who will be selected), the President-Elect, and one of the Executive Secretaries; and that in the future, attendance at the AMA Annual and Clinieal Conventions be stipulated in advance of each.

Professional Committee — Membership

Accepted the resignation of Jack D. Fatheree, M.D., as a member of the Professional Committee of this Association; and directed correspondence with the President of the Maricopa County Medical Society, Dr. Arthur R. Nelson, informing him of this action and requesting nominations from the Society, candidates who will be agreeable to accept appointment to fill this vacancy on the Professional Committee for the unexpired term 1968-71.

MEETING ADJOURNED AT 1:15 P.M.

John P. Heileman, M.D.
Secretary

KEEP APRIL 22 thru 26, 1969 OPEN

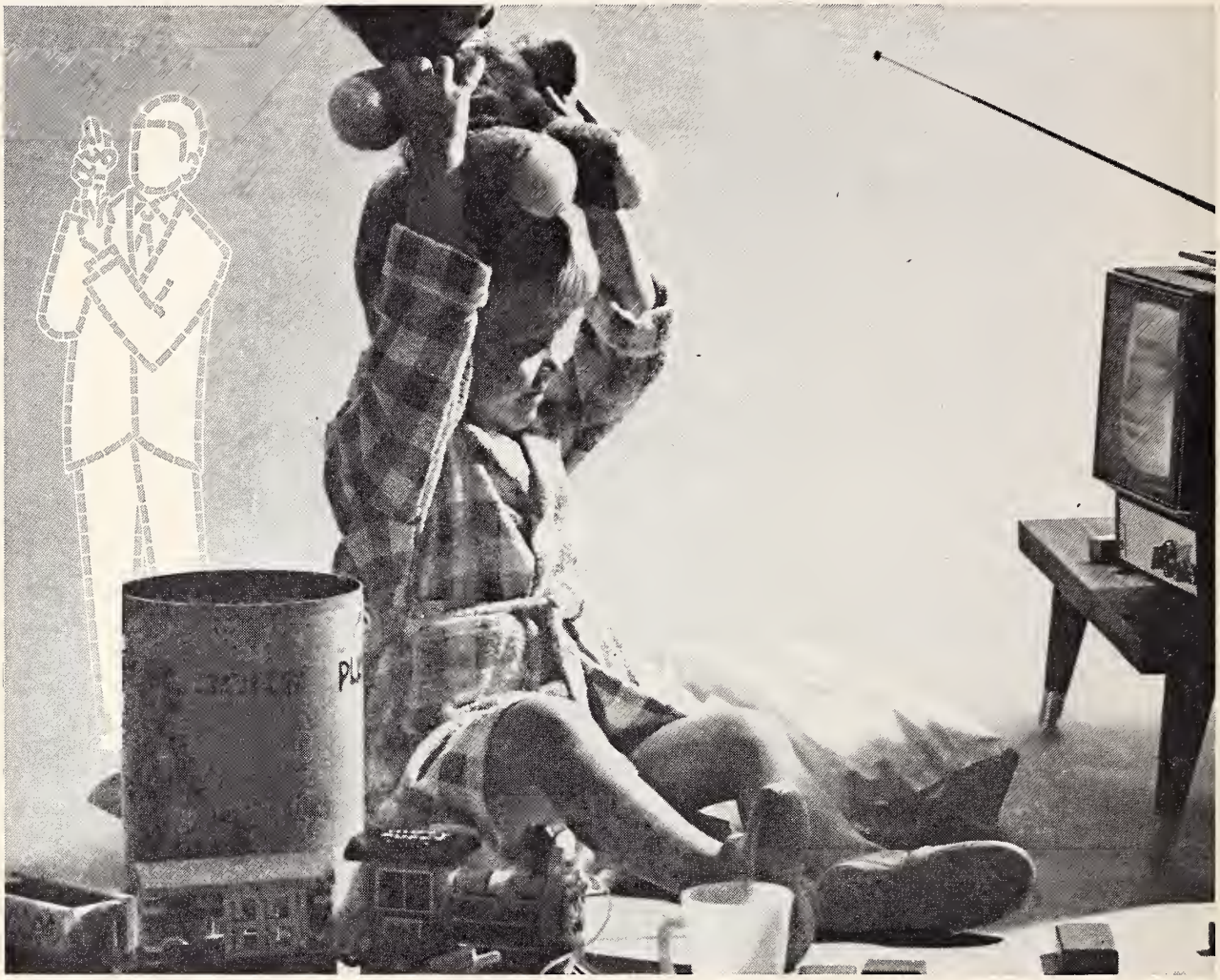
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It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

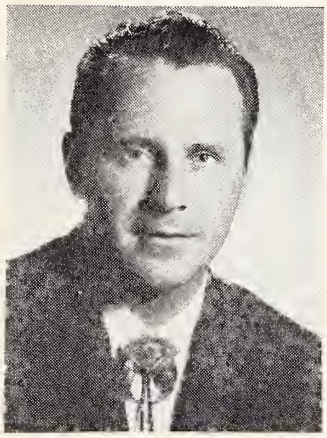
V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A] 800198

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

TWO YEAR FOLLOW-UP STUDY OF TREATMENT OF ASTHMA WITH INTERMITTENT CORTICOSTEROID DOSE SCHEDULE



Robert C. Briggs, Jr., M.D.

Long term corticosteroid treatment of bronchial asthma has been limited by the development of undesirable side effects. Ten severe asthmatic patients reported here were treated with an intermittent dosage schedule for as long as 30 months. Good results were obtained with a minimum of side effects.

The history involving corticosteroids in the treatment of many diseases has been long and varied and accompanied by and sometimes stymied by undesirable side effects. Many attempts have been made in the past to evaluate steroids in auto-immune diseases. Because of the side effects an intermittent technique rather than a continuous daily dosage has been investigated.

A report appeared in 1963 by Doctors Harter, Redd and Thorn in which Dr. Harter reviewed at that time a forty-eight (48) hour intermittent dosage schedule which rendered the patient virtually asymptomatic from his primary disease without the introduction of a secondary disease.[1] He also found that the patient's adrenal function was scarcely disturbed on this type of regimen in which high doses of Prednisone were employed as opposed to the daily regimen in which there was found to be suppression of the adrenals. In 1959 Dr. Siegel studied the effects of intermittent steroid therapy in allergic children; there he employed a three-day schedule on followed by a four-day schedule off.[2] He found in children that the 17 hydroxy-steroids were down after several months of this type of therapy. Dr. J. A. Weaver in 1966 studied sixty-nine (69) patients with severe rheumatoid arthritis and

bronchial asthma treated with corticotrophin gel intramuscularly by an intermittent dosage schedule and found gratifying clinical results and no suppression of the adrenal function either in the controlled or treated group.[3] The effects of using long term daily steroid therapy in asthma are well known.[4]

In this report an attempt is made to evaluate the clinical response of the intermittent steroid dosage schedule on ten (10) severe asthmatics who were found to be refractive to the conventional asthmatic treatment or whose asthma was only partially controlled and had to present for repeated treatments, either to the hospital or to the office. The conventional treatment included the treatment for the acute attack using adrenalin, intravenous aminophyllin, fluids and antibiotics. Poor response to treatment was equated to no results from the treatment of the acute attack thereby necessitating steroids or to repeated office or emergency room visits while on Tedral or some other bronchial dilator commonly employed in the treatment of chronic asthma. It therefore seemed justified in these patients to use steroids; however, because of the deleterious effects of massive dosages of steroids it was decided to use the intermittent schedule. The group consisted of five (5) males and five (5) females. Each patient was started out on a dosage of sixty (60) mgm to eighty (80) mgm of Prednisone given once each morning every forty-eight hours for a period of one to two months then to a maintenance of ten (10) mgm to thirty (30) mgm every other day. This was varied according to the symptoms of the patient. No other drugs were used.

Results

Of the ten (10) patients (see accompanying chart) eight (8) had total improvement clinically as well as complete clearing of the chest on auscultation. One patient (V. M.) although completely cleared required in addition conventional antiasthmatic drugs. One other (R. R.) although clinically improved was found two years later to persist in auscultatory wheezing. None of the patients were made worse by the therapy and there were no side effects, such as loss of hair, hypertension, diabetes, fractures, ulcers, weight loss or gain, electrolyte imbalance or psychosis. Many of the patients required only a short course of therapy of one or two months and have remained asymptomatic. Others have found that they are not able to be controlled without the Prednisone. Attempts were made at the second year level to remove patients from the drug, but this was met with recurrence of the asthma.

It is interesting to attest to the severity of the asthma prior to treatment that six (6) of the ten (10) patients had to be admitted to the hospital for therapy. One man (C. T.) had not been able

Patients' Initials	Age	Sex	Race	Past History Asthma	Status of Patient When Program Was Initiated	Initial Dosage	Maintenance Dosage	Months Since Treatment Began	Result
W.Z.	19	M	W	3 yrs.	Office	70 mgm	30 mgm	4 continuous 7 intermittent	Improved
L.S.	46	M	W	2 mos.	Hospital	80 mgm	25 mgm	4 continuous 8 intermittent	Improved
V.M.	63	M	W	15 yrs.	Hospital	80 mgm	60 mgm	4 discontinued	Improved
B.H.	44	F	W	7-8 yrs.	Hospital	70 mgm	25 mgm	2 discontinued	Improved
R.J.	44	M	W	3 wks.	Office	70 mgm	30 mgm	8 continuous	Improved
J.V.	77	F	W	11 yrs.	Hospital & Office	80 mgm	20 mgm	12 discontinued	Improved
M.M.	39	F	W	30 yrs.	Office	50 mgm	5 mgm	31 continuous	Improved
R.R.	39	F	W	30+ yrs.	Office	80 mgm	20 mgm	32 continuous	Improved
V.H.	25	F	W	25 yrs.	Hospital	70 mgm	30 mgm	2 continuous 10 intermittent	Improved
C.T.	67	M	W	20 yrs.	Hospital	80 mgm	25 mgm	25 continuous	Improved

to work for twelve (12) years and had not obtained relief from allergy injections. After twenty-five (25) months on twenty-five (25) mgm Prednisone q.o.d., he now works six (6) days a week in a liquor store of which he is the owner.

Another man (L. S.) worked as a carpenter and was planning to give up his job because of the dust. It is now twelve (12) months later; he is on twenty-five (25) mgm Prednisone q.o.d., he is working and his lungs are clear of wheezing.

A woman (B. H.) worked as a beautician and was about to leave her position because of questionable allergy to the dyes. Twelve (12) months later on twenty-five (25) mgm q.o.d., she is still working without difficulty and her lungs are clear.

Discussion

It is apparent that in the above study all the patients improved and all but one were rendered completely clear of wheezing on ascultatory examination. It is noteworthy to mention that some of the older patients undoubtedly had emphysema as well as asthma.

There has been some dispute as to the site of action of adrenal steroids. It is not within the scope of this paper to shed light on this subject except to say that there appears to be in addition to an anti-inflammatory effect on tissue, a definite change in serum antibodies in such diseases as lupus, erythematosis and other "allergic vasculitis" type diseases, upon the introduction of steroids. This might suggest a more central mechanism of action.

A consideration for the use of ACTH instead of adrenal steroids is noted in Thorn's article[5] in which he states that the use of ACTH is impracticable both from the day-to-day steroid response and because the injections increase the salt and water retention by the stimulation of the adrenal gland.

Although this article is concerned with adults, a comment on the use in children is warranted, because of the crippling effects which begin in the young which might be reversed or curtailed if treatment is initiated. Dr. Tollackson in 1965 reviewed the effects in children.[6] He concluded that the results in long term therapy have been good; however, Siegel and co-workers found adrenal suppression using Beta-methasone in children on the forty-eight hour schedule.[7]

More recently Harter and co-workers used ACTH once a month which allowed for reduction in the dosage of steroids used in the forty-eight hour schedule.[8]

At this time it is difficult to assess the effects on adrenal function, except to say that no side effects were attributed to the drug, including disturbance in carbohydrate metabolism, hypertension, fluid retention, development of ulcers, or fractures were observed. It is planned to perform ACTH stimulation on the patients who pass the two-year period and can discontinue the steroids. It should be noted, however, that no overt signs of adrenal insufficiency developed on attempts to discontinue steroids.

Summary

Ten (10) patients, five (5) females and five (5) males, who were found to be refractory to conventional asthmatic treatment were begun on Prednisone in doses of sixty (60) to eighty (80) mgm on an intermittent schedule for a period of one (1) to thirty (30) months with an average maintenance dose of ten (10) to thirty (30) mgm q.o.d. Nine (9) patients experienced complete remission of symptoms and were clear on auscultation. One (1) patient, although improved, continued to have rales and wheezing; another improved but other drugs were necessary.

It is the opinion of the author that the primary purpose is to keep the asthmatic patient free from wheezing. Even low grade inflammation will eventually lead to irreversible lung damage and hence a pulmonary cripple. If the patient can be handled by conventional therapy or allergy injections, this to date would seem the treatment of choice. However, refractory cases should be given the benefit of steroids in the intermittent dosage schedule and should subsequent reports establish the concept alluded to in previous articles, namely that there are minimal side effects and virtually no adrenal suppression, then this factor combined with the convenience of treatment would favor this type of therapy.

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PARGYLINE HYDROCHLORIDE AND METHYCLOTHIAZIDE COMBINED IN THE TREATMENT OF HYPERTENSION IN DIABETIC PATIENTS

Nineteen diabetic patients with hypertension were treated with a combination of pargyline and Methyclothiazide (Eutron) for 16 weeks. Blood pressure control was good in 17 patients and few unmanageable side effects occurred.



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Pargyline hydrochloride is a potent inhibitor of the enzyme, monoamine oxidase, but differs chemically in that it is not a hydrazine compound as most MAO inhibitors are, and it produces a useful antihypertensive effect unlike other drugs of this family.

A number of reports have appeared in the literature concerning the antihypertensive effect of pargyline hydrochloride used alone[1-7] and in combination with methyclothiazide,[8-17] a member of the benzothiadiazine series of diuretic-antihypertensive agents.

The combined use of these compounds is said to produce a greater antihypertensive effect than could be expected from either drug alone and to reduce the number of side effects by reduced dosage.[8-11]

One interesting aspect of these two drugs is the apparent opposite effects of these two classes of compounds on blood sugar levels. Monoamine oxidase inhibitors have been shown to potentiate insulin and sulfonylurea hypoglycemia[18, 19] as well as exert their own hypoglyemic effects.[20] Thiazides, on the other hand, are known to induce hyperglycemic effects.[21-27]

Since diabetes and hypertension are frequently complications to each other, knowledge of the effects of MAO inhibitor — thiazide combination becomes clinically important. The purpose of this study was to explore the usefulness of a pargyline hydrochloride-methyclothiazide combination as an effective antihypertensive agent which would not interfere with established stabilizing dosages of oral sulfonamide or insulin in diabetic patients.

Materials and Methods

Nineteen diabetic patients with elevated blood pressure were selected from private practice for study. Except for one Negro and one patient of Spanish descent, all were Caucasian. Included were twelve women and seven men averaging 54 years (range 23 to 70). Table 1 shows the duration of hypertension and diabetes for each patient.

The antihypertensive drug combination was supplied in the form of tablets containing pargyline hydrochloride (25 mg.) and methyclothiazide (5 mg.). The initial dose of this combination and the final dose used to control blood pressure are also given in Table 1, along with the anti-diabetic medication used to control blood glucose levels.

Blood pressure readings were taken in the standing, sitting, and supine positions at inter-

Table 1.

Duration of Hypertension and Diabetes, Medication and Dosage

Patient #	Duration of Hypertension	Eutron Initial Dose	Eutron Stabilizing Dose	Duration of Diabetes	Insulin Type	Unit Dosage	Hypoglycemic Agent	Dosage mgm/day
1	new	½ tab daily	1 tab daily	new			Tolbutamide	2000
2	new	½ tab daily	½ tab daily	new			"	500
3	1	½ tab q.o.d.	½ tab daily	new			"	1000
4	10	½ tab daily	½ tab daily	new			"	1500
5	2	1 tab daily	1 tab daily	12			Phenformin	100
							Chlorpropamide	250
6	6	½ tab daily	½ tab daily	15	NPH	60		
7	1	½ tab daily	½ tab daily	2			Chlorpropamide	500
8		½ tab daily	1 tab daily	18	Lente	40		
9	3	½ tab daily	½ tab daily	15	Regular	10		
					NPH	40		
10	2	½ tab daily	½ tab daily	5			Phenformin	50
11	5	½ tab daily	1½ tab q.o.d.					
			1 tab q.o.d.	new			Tolbutamide	1500
12		½ tab q.o.d.	½ tab b.i.d.	new			"	750
13		½ tab daily	½ tab daily	2			"	500
14	2	½ tab daily	½ tab daily	10	Lente	30		
15	3	½ tab daily	2½ tab daily	4			Tolbutamide	1000
16	2	1 tab daily	1½ tab daily	20	Semilente	43		
					Ultralente	33		
17	2	½ tab daily	1 tab daily	new			Phenformin	50
18	8	½ tab daily	½ tab daily	3			Tolbutamide	750
19	4	1 tab daily	1 tab daily	13	Lente	65		
Average	3 years			6 years				

vals of 1, 2, 4, 8, 12, and 16 weeks. Control determinations were made once a week over a period of four weeks prior to the start of the pargyline-methyclothiazide therapy. Eleven patients were on previous and/or current antihypertensive medications, so "control" or starting blood pressures in these patients therefore represent baseline values for these medications.

Fasting blood glucose concentrations were recorded at the end of the 4th, 8th and 12th week of pargyline-methyclothiazide therapy. Blood urea nitrogen determinations were also carried out at these same intervals to monitor renal function. Control levels of glucose and BUN were taken four weeks and immediately prior to the start of pargyline-methyclothiazide treatment. Control levels therefore also represent baseline values with the particular antihypertensive diabetic regimen in use at the time the study was initiated.

Results

Table 2 shows the average of all standing, sitting, and supine blood pressures by week. Normotensive ranges (140/90 mm. Hg or less), on the average, were obtained by the 4th week and were maintained through the 16th week of treatment when the systemic observations needed for study purposes were discontinued.

Thirteen patients achieved and maintained normotension. Four others obtained a drop of 20 mm. Hg (mean B.P.) but did not reach normotension. By these two criteria, the results were very satisfactory with 17 patients (89%) showing improvement. It should be noted that the remaining two subjects did, at some time during treatment, attain normotension. However, these are not included in the improved category because they did not maintain normotension throughout the study. The absence of the orthostatic effect was of particular interest since this has been attributed to pargyline used alone. No subject showed consistent blood pressure differences greater than 10 mm. Hg between standing, sitting, and/or supine positions throughout the entire study. While the orthostatic effect was apparent in six patients at some time during the study, the differences between positions were not always in the same direction. Further, these patients were receiving other drugs. In general, the results of this study support the idea of Shafer[13], who states that the orthostatic effect is largely overcome by the use of combined therapy with pargyline and methyclothiazide.

Pulse rate did not change appreciably for any of the patients during therapy, nor did it vary from the control pulse rate recorded immediately prior to the start of treatment.

Fasting blood sugar levels and blood urea nitrogen concentrations for each patient are shown in Table 3. Although the average glucose level during treatment was substantially lower than pre-treatment average, it was somewhat higher than the upper limit of normal (110 mg./100 cc.). In terms of individual treatment success, ten patients maintained normal fasting blood glu-

Table 2

Average Blood Pressure Response to Pargyline and Methyclothiazide

	Week	Standing	Mean	Sitting	Mean	Supine	Mean
Pre-treatment Average	1	162/98	119	162/99	119	161/99	119
	2	159/97	118	160/96	117	157/97	117
	3	160/97	118	157/95	116	161/96	117
	4	161/98	119	160/95	117	161/97	118
Post-treatment Average	1	153/93	111	150/92	111	150/93	112
	2	147/91	110	149/90	109	148/91	110
	4	140/81	104	141/86	104	141/83	104
	8	136/85	102	135/84	101	137/84	101
	12	137/84	102	137/83	101	138/81	100
	16	137/82	101	138/81	100	139/81	100

Table 3

Blood Glucose and Blood Urea Nitrogen Data

Patient	Fasting Blood Glucose Mgm%					Blood Urea Nitrogen Mgm%				
	Week					Week				
	Pretreatment		Treatment			Pretreatment		Treatment		
	-4	0	4	8	12	-4	0	4	8	12
1	105	115	100	95	138	16.0	18.0	12.4	12.8	16.5
2	184	120	112	109	84	12.4	14.9	16.2	13.0	11.0
3	114	110	105	100	109	13.5	16.2	14.0	13.0	12.0
4	105	88	93	86	78	17.9	16.0	15.4	18.2	14.1
5	162	110	101	92	110	10.4	13.6	12.2	8.0	16.4
6	133	170	310	150	160	8.0	12.0	16.0	15.4	10.0
7	351	330	148	135	172	19.0	14.5	15.0	16.0	13.2
8	330	265	182	298	229	16.0	16.0	12.0	15.9	21.0
9	350	251	271	269	154	13.6	14.0	11.0	9.8	12.0
10	146	87	100	94	98	12.0	10.0	10.0	8.0	12.0
11	197	75	83	89	94	7.2	8.4	12.1	10.6	9.3
12	106	102	80	94	86	14.0	13.5	9.0	10.2	11.2
13	190	105	96	89	92	18.4	21.0	22.0	17.4	20.0
14	275	400	60	168	90	10.0	8.9	13.7	16.9	15.0
15	89	84	75	80	92	16.0	14.0	22.2	13.0	15.0
16	205	265	148	92	320	24.5	28.0	29.2	26.5	28.0
17	79	113	110	105	98	10.8	14.5	16.0	11.4	12.6
18	84	106	123	97	89	17.2	16.5	18.5	15.8	16.9
19	250	203	185	150	130	12.0	10.0	14.0	13.0	9.0
Average	182	163	124	126	128	14.2	14.7	15.8	13.9	14.5

eose levels throughout treatment. Four others attained normal eoneentrations at some time during treatment. One of these patients (1) was lax about adhering to his low-purine diabetie diet, and this may have eontributed to his unstable glueose level. In two other patients (7, 14) blood sugar variations were attributed to weight fluetuations. One of the patients (9), showed an extraordinary drop in blood sugar level (350+ mgm. % to 154 mgm. %), and the insulin requirement was redueed from 60+ units to 43 units. In the overall, sixteen patients were maintained on the original stabilized dosage of anti-diabetie medieation. One patient (6) reeeived an inerease of insulin from 60 units of NPH to 80 units. Data on the ehange in dosage are not available for the other two patients.

With the exeeption of one patient (16), BUN levels were eonsistently below the upper normal eoncentrations (20 mm./100 CC.) during both pretreatment and treatment periods, suggesting that kidney funetion is unaffeeted by the pargyline-methyelothiazide eombination. BUN eoneentrations also show a random distribution with time.

The drop in average in fasting blood sugar eorresponded to the drop in mean average and blood pressure by the fourth week, followed by stabilized levels for the remainder of the study. On an individual basis, however, there was no apparent eorrelation between blood pressure or dosage of medieation with fasting blood sugar levels, either in eoneentration or direetion of ehange with time. These results are similar to those of Rangle[20] who also found no eorrelation between blood pressure and blood sugar changes. The faet that quantitative relationships between the pargyline-methyclothiazide eombination and diabetie state eould not be established indieates that this antihypertensive drug eombination does not interfere with any of the anti-diabetie regimens used in this study.

Table 4 shows a summary of the side effeets possibly attributable to the drug therapy, eoneurrent eonditions present, and additional medieation used for eaeh of the patients. In general, treatment went well, with few unmanageable side effects and no induetion of other eomplications. There were two additional patients whose reeords have not been ineorporated in this study

Table 4.

Additional Individual Patient Data

Patients	Possible Drug Side Effects	Other Conditions Present	Additional Medication
1		gouty arthritis	Butazolidin-alka diabetic diet
2		chronic asthmatic bronchitis paranoid schizophrenia	Amesec
3		cranial arteritis	
4		arteriosclerosis	
5		atherosclerosis	
6		secondary infection	
7	weight fluctuation		
8		pregnancy - no complications	
9			
10			
11			
12			
13		arthritis	Dexamethasone
14	symptoms of cold weight fluctuation	vertigo*	
15	irritability upset stomach rash		Valium
16	light-headedness mood lability		
17	tension headache		1000-caloric diabetic diet
18	rash on ankles & knee dizziness & ringing in ear	cerebral atherosclerosis	relieved by anticoagulants
19	nervousness headache tired feeling		

* antedates beginning of treatment

because of refusal to continue treatment. One complained of dizziness after three weeks, and the other had frequent syncopal episodes after 8 weeks.

Comment

The mechanisms that underlie the antihypertensive effects of monoamine oxidase inhibitors are not well understood. Theoretically, it would be expected that MAO inhibitors would prevent the breakdown of catecholamines; which by their accumulation would cause a rise in blood pressure. The fact that pressures are actually lowered suggests that their action on the cardiovascular system may follow some process unrelated to MAO inhibition.

The hypoglycemic action of MAO inhibitors is just as paradoxical since one would assume that the production of an increase in endogenous monoamines, as the result of amine-oxidase inhibition, would have enhanced the metabolic actions of adrenaline and thereby produce a rise in blood-glucose rather than a fall.

Kotin[29] suggests that pargyline induces the formation of a "false neurochemical transmitter" which replaces norepinephrine in adrenergic nerve endings and which, in turn, inhibits postganglionic sympathetic transmission.

Cooper and Ashcroft[18, 19] believe that "an alalagous situation might be present in the case of adrenalin which would manifest itself clinically as a partial failure of those homeostatic functions subserved by that amine — specially in diabetes, a failure of the compensatory adrenalin response following insulin, or sulfonylurea hypoglycemia."

The same authors call attention to the difference in the degree of hypoglycemic action caused by hydrazines, which significantly potentiated and prolonged insulin-induced hypoglycemia, as opposed to the nonhydrazines which did not potentiate the fall of blood sugar after insulin but, like the hydrazines, still delayed the time of recovery.

The hyperglycemic effects of thiazide compounds are also not well understood. Brown[22] in his attempt to eliminate several of the variables uncontrolled in previous studies of the problem,[23, 27] focused attention on changes in response to determine if carbohydrate handling ability was impaired by thiazides. His long-term study did indicate a diminution of carbohydrate tolerance. He also presents evidence that the rise in serum uric acid levels which often occurs in thiazide therapy is unrelated to diabetogenic effect.

Brown also discards the idea of glucose intolerance being mediated by hypokalemia as was suggested by Rapoport and Hurd.[28] The exact mechanism of thiazide-induced glucose intolerance still remains to be found.

Ignorance must be pleaded in still another area — the manner by which thiazides lower blood pressure. An excellent review on the subject of thiazide diuretics and essential hypertension by Tobian[30] brings to the fore two possible explanations of thiazide action. One is the enhancement of sodium excretion in which an adaptation occurs to bring about a drop in arterial pressure and peripheral resistance. The other explanation is that thiazides reduce the amount of norepinephrine liberated with each nerve impulse.

Nineteen diabetic patients with high blood pressure received a combination of pargyline hydrochloride and methyclothiazide for sixteen weeks. Standing, sitting, and supine blood pressures, fasting blood glucose concentrations, and blood, urea nitrogen levels were recorded. Seventeen patients (89%) showed good antihypertensive response. Ten patients maintained normal blood glucose levels throughout the study while four others attained normal levels at some time. There was no consistent correlation between blood pressure or dose of pargyline-methyclothiazide with fasting blood sugar levels. There were few unmanageable side effects and no induction of other complications.

The combination of pargyline hydrochloride and methyclothiazide used in this study was supplied as Eutron® by Abbott Laboratories, North Chicago, Illinois.

Generic and Trade Names of Drugs

Pargyline hydrochloride and methyclothiazide — Eutron
Chlorpropamide — Diabinese
Dexamethasone — Decadron, Dcronil
Diazepam — Valium
Insulin — Iletin
Phenformin — DBI
Phenylbutazone — Butazolidin
Aminophylline — Amesec
Tolbutamide — Orinase

Varied and general usage.

Diabetes
Hypertension
Antihypertensive Agents
Pargyline Hydrochloride
Methyclothiazide

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INFLUENZA PROSPECTS AND RECOMMENDATIONS FOR IMMUNIZATION 1968-69

Division of Preventive Medical Services
Arizona State Department of Health

OCCURRENCE OF INFLUENZA IS PREDICTABLE WHEN INFORMATION IS AVAILABLE ON RECENT PRESENCE OF THE VARIOUS TYPES AND THE ATTENDANT MORBIDITY. THIS KNOWLEDGE IS ALSO THE BASIS FOR DETERMINING THE ANTIGENIC COMPOSITION OF VACCINE. REPORTS FROM PHYSICIANS PROVIDE MUCH OF THE DATA USED FOR THESE PURPOSES.

About this time each year speculation begins on the possibility for outbreaks of influenza and questions arise concerning indication for immunization. Tenable anticipation of outbreaks is possible since influenza occurs in successive waves of infection attributed to specific types of virus.

Two types of virus, A and B, are commonly involved in widespread outbreaks. Antigens of both types are unstable and at least three subtypes are known for each group. Type C influenza virus is stable and has been identified only in sporadic cases and localized outbreaks.

Waves of influenza attributed to Type A virus occur at intervals of 2 to 3 years. Influenza B does not spread as rapidly as Influenza A and peaks are reached at intervals of 3 to 6 years. The interval between epidemic waves is due primarily to the persistence of immunity.

Recent occurrence of influenza in the U.S.

During the fall and winter of 1967-68 outbreaks of influenza-like illness were reported for all states except Oregon, California, Idaho, and Nevada. Influenza virus A2 (Asian influenza type) was identified in 40 states. Epidemics of Influenza B were last reported in 1965-66 in the eastern United States and in 1966-67 in the western states.

On the basis of national experience, evidence available early this year suggested that occurence of A2 influenza would be negligible except perhaps on the Pacific Coast. Extensive occurrence of Type B influenza is unlikely although scattered cases and localized outbreaks may occur.

Hong Kong Virus

The position with respect to A2 influenza was revised following an outbreak of influenza A2 in Hong Kong during July 1968. Strains of influenza virus from this outbreak cross-react to some extent with previous A2 strains but do reflect major antigenic differences. The Hong Kong strains subsequently were isolated from cases of influenza imported from Asia and from their contacts in the United States. The presence of this A2 variant has greatly enhanced the possibility of outbreaks of A2 influenza in the United States during 1968-69.

Influenza prospect for Arizona during 1968-69

Recent data concerning occurrence of influenza in Arizona are shown in Figures 1 and 2. The monthly number of cases shown in Figure 1 is based on weekly reports from physicians. Since only 16 per cent of physicians provide reports, the number of cases indicated probably is a minority of those that occurred. However, trends in occurrence and seasonal distribution of cases probably is reflected accurately. The reporting

Table 1

Composition of influenza vaccine for 1968-69

Type	Strain	CCA units per adult dose			
		Bivalent		Polyvalent	
A	PR/8/34	-			100
A1	Ann Arbor/1/57	-			100
A2	Japan/170/62 Taiwan/1/64	150 150	300	100 100	200
B	Mass/3/66		300		200
	Total		600		600

system provides for recording respiratory diseases of undetermined etiology as well as influenza.

Figure 2 indicates the monthly number of deaths attributed to influenza and pneumonia (International Classification of Diseases. Codes 480-493). Also shown is the 5-year mean occurrence and the epidemic threshold calculated as 1.65 standard deviations of the 5-year mean.

During the most significant recent outbreak in 1965-66, the number of deaths increased more than threefold. During the peak, more than 5,000 cases were reported during a single week. This outbreak was attributed to A2 virus on the basis of work at the Laboratory of the State Department of Health that resulted in isolation of virus and detection of rises in antibody titer.

An increase in reported absences of school children in Pinal County late in April 1967 heralded the appearance of Influenza B in the winter of 1966-67. Sporadic outbreaks subsequently were detected in several other areas of the state. Characteristically the course of illness was mild and no excessive deaths were recorded (Figure 2). Although school absenteeism was excessive in the affected areas the presence of the disease was not apparent from morbidity reports provided by physicians. This may be explained, at least in part, by the mild nature of illness caused by Influenza B virus for which medical attention frequently is not sought.

Influenza A2 again was reported in Arizona during the winter of 1967-68. A small localized outbreak was detected in the Bisbee area of Cochise County in November. The peak reached in January and February was well below that of 1965-66 (Figure 1). The apparently limited involvement of Maricopa County probably accounted for the low peak. No excessive deaths from influenza and pneumonia were recorded in Arizona (Figure 2) in contrast to experience elsewhere in the United States.

Considering the epidemiological pattern of occurrence and recent experience in Arizona, Influenza A2 may occur in Arizona during the winter of 1968-69. Involvement of the Phoenix metropolitan area is likely in view of apparent low prevalence of A2 virus in the two previous years and the possible occurrence of A2 virus on the west coast. As may be inferred from data in Figure 2, many susceptibles succumbed during the epidemic of 1965-66 and presumably persons at high risk have accumulated in the population since that time.

Necessity for reporting influenza

Anticipation of outbreak and decisions of the Advisory Committee on Immunization Practice for formulation and recommendations for use of influenza vaccines necessarily are based upon epidemiological and laboratory data. This information must be obtained each year at the time influenza is prevalent. Reporting of morbidity and submission of specimens by physicians to the State Department of Health are sources of the most useful information.

Rationale for immunization*

Selective immunization is suggested in recognition of the limitations of influenza vaccines which are among the least satisfactory immunizing agents in general use. Inconsistency in the levels and durability of vaccine induced antibodies preclude indications for routine use of influenza vaccines among healthy groups of

*The remainder of this note is quoted directly or paraphrased from Recommendations of the Public Health Service Advisory Committee on Immunization Practices, Influenza Vaccines — 1968-69. Morbidity and Mortality Weekly Report. 17:26, 246-247, June 20, 1968.

adults and children.

Effectiveness of vaccines depends primarily upon antigenicity of the virus components and their similarity to the wild viruses occurring in the community. Also important is the amount of antigen administered. The Division of Biologics Standards, National Institutes of Health, to minimize local and systemic reactions associated with

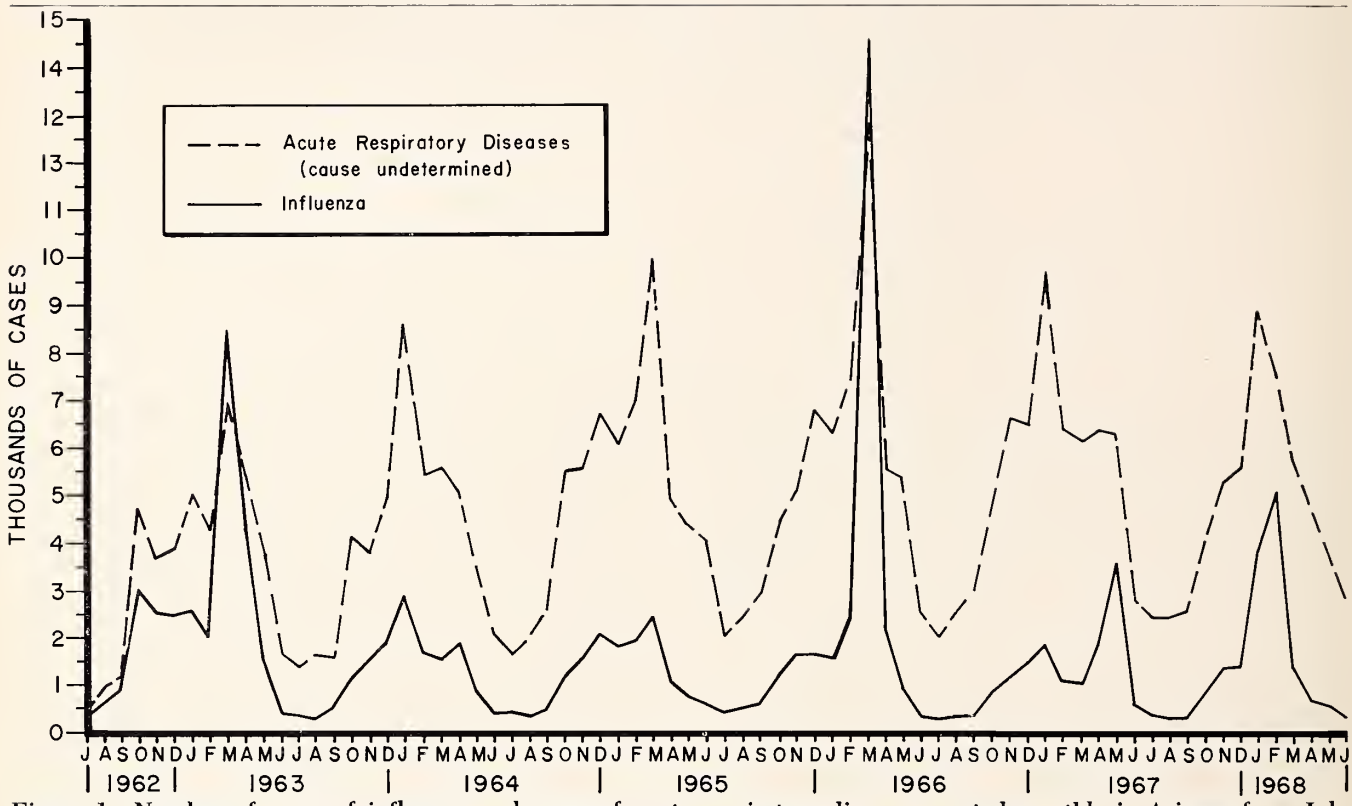


Figure 1. Number of cases of influenza and cases of acute respiratory disease reported monthly in Arizona from July 1962 through July 1968.

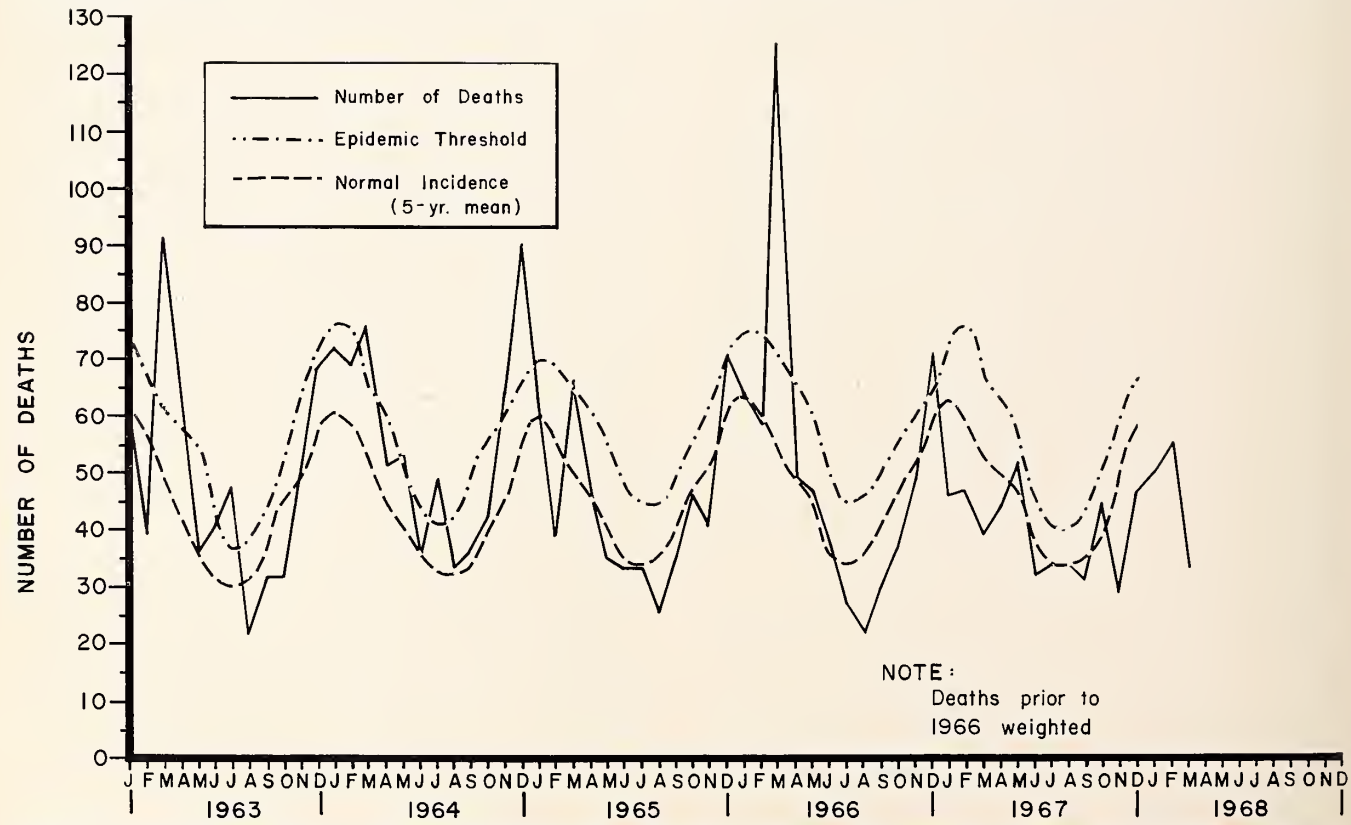


Figure 2. Monthly number of deaths reported, average number of deaths by months for 5 years, and epidemic threshold of deaths from influenza. Arizona, January 1963 through April 1968.

influenza vaccines, established a limit of 600 chick cell agglutinating (CCA) units of antigen per adult dose of vaccine.

A new highly purified vaccine of bivalent formulation was introduced in 1967. It has the advantage of more CCA units of the contemporary A2 (Asian) and B strains of the virus. The older A and A1 strains were omitted because these virus strains are no longer prevalent. Because the bivalent vaccine contains substantially less extraneous material than the older polyvalent vaccine, reactions have been fewer and less severe. During the 1968-69 season, both bivalent and polyvalent vaccines will be available. Compositions of these vaccines are shown in Table 1.

Recommendations for use of vaccine

Each year the Public Health Service Advisory Committee on Immunization evaluates the recent history of influenza and anticipates probable occurrence during the next winter. Recommendations then are made for use of vaccines for the nation as a whole.

The Arizona State Department of Health recommends influenza immunization for persons in groups known to experience high mortality from influenza. Specifically bivalent vaccine is advisable for persons with chronic illnesses and older persons, as defined below. When epidemics are probable, persons providing essential services also should be immunized.

Chronically ill: Persons of all ages who suffer from chronic debilitating diseases, including cardiovascular, pulmonary, renal, or metabolic disorders: 1) patients with rheumatic heart disease, especially with mitral stenosis; 2) patients with such cardiovascular disorders as arteriosclerotic heart disease and hypertension, especially showing evidence of frank or incipient cardiac insufficiency; 3) patients with chronic bronchiectasis, pulmonary fibrosis, pulmonary emphysema, or pulmonary tuberculosis; and 4) patients with diabetes mellitus and Addison's disease.

Older age groups: During major outbreaks, especially those caused by Type A viruses, increased mortality has regularly been recognized for persons over 45 years of age and even more notably for those over 65. This association has been particularly marked in individuals with underlying chronic illness.

Schedule for immunization

All injections should be given subcutaneously.

Persons vaccinated after July 1963 (date of the latest major choice in A2 components): Only a single booster of bivalent vaccine at the dosage level specified below is necessary for individuals for whom immunization is indicated and who have been vaccinated as recently as July 1963. This booster dose is best given in early December, which is approximately one month before the beginning of the usual influenza season.

Persons not vaccinated since July 1963: Persons for whom immunization is indicated and who have not been vaccinated since July 1963 should receive a primary immunization series of bivalent vaccine. The optimal primary series consists of two doses 2 months apart. Even a single dose will afford some protection, and a second injection as early as 2 weeks after the first will enhance the antibody response. Immunizations should be scheduled to be completed by early December.

Vaccine dose

(The equivalent dose volume of highly purified vaccine is indicated by the manufacturer.)

Adults and children over 10 years old: 1.0 ml on one or two occasions as specified above.

Children 6 to 10 years old: 0.5 ml on one or two occasions as specified above.

Children 3 months to 6 years old: 0.1-0.2 ml of vaccine on two occasions 1-2 weeks apart, followed by a third dose of 0.1-0.2 ml about 2 months later. Since febrile reactions in this age group are common following influenza vaccination, an antipyretic may be indicated.

Reactions

Reactions to regular influenza vaccines are thought to be related primarily to the non-viral components of the vaccine and commonly include erythema, induration, and tenderness at the site of injection. Systemic reactions of fever, headache, and malaise also occur, but less frequently.

For older individuals who should receive influenza vaccine but have experienced severe local and systemic reactions following receipt of regular vaccines, full doses of a highly purified influenza vaccine should be considered. Intracutaneous administration of regular vaccines had previously been used in these older age individuals but is less effective than full doses of vaccine given by the subcutaneous route.

Contraindications

Since the vaccine viruses are propagated in eggs, the vaccine should not be administered to anyone who is hypersensitive to eggs.

President's Page

WHO IS *YOUR* FAMILY DOCTOR?

Who is the one person you can confide in and whose wisdom and guidance you can accept?

As all of you well know, I am a G.P. Until recent years the G.P., or family doctor, was the man who delivered the baby, did the tonsillectomy, advised the newlyweds, took care of the children, parents and grandparents and, when necessary, sat with the great-grandparents as they passed to their reward. Is there anyone who reads this that does not remember that kind doctor who, when you were ill, sat at your bedside and comforted you?

Who is *your* family doctor?

While some may disagree, it matters not whether your family doctor is a G.P., Pediatrician, Internist, Surgeon, Orthopod or Dermatologist. No one man is adept in all fields of modern medical practice, but one man can be your family confidant.

One man *must* be your *family doctor.* This is a very strong statement, but one which I believe is the salvation of good medical care now and in future years. This is PR.

What is PR? PR is "Public Relations" that each of us practices with each patient we see or treat. Public Relations is an intimate part of our profession. Most of us, as Doctors of Medicine, fail in Public Relations. Most of us fail as the "family doctor." We are upset when our "families" seek medical care, good or bad, without our advice. When this happens, we have failed in "Public Relations" with our "family." We have failed because we did not have the opportunity to give any advice.

None of us would go to the gardener for stock market advice. Would any of us go to the automobile salesman for home-building or office management advice? Yet we do allow our patients, or "families," to go to their neighbors, or the newspaper or the popular magazines for their medical advice. We, collectively, have failed in Public Relations.

Our best Public Relations is with the patients we treat day in and month out. Our next best Public Relations is the daily newspaper, radio, TV. But our "Code of Ethics" prohibits or restricts use of our name in a lay publication. Why? Please do not misunderstand — I do not believe in professional advertisements — I believe the "Why?" is best answered by we doctors who, through our "Code of Ethics" wish to be clothed in anonymity and will not take a positive stand on any issue. Our "Code" is outdated, but basically sound, and must be re-evaluated by today's standards. If we fail in this undertaking we will lose our Public Relations. When we lose this, medical practice, as we know it today, will never be the same.

As a family physician I have a financially and emotionally rewarding practice. As a Pediatrician, Internist, Surgeon or Orthopod (or any medical specialist) I hope you can say the same. But first and foremost we are Doctors of Medcine. Our Public Relations is a little tarnished. With individual effort I'm sure the tarnish will turn to shine. Whether we speak of the individual's "family doctor" or 300,000 doctors as the "family doctor" for 21 million citizens of the U.S., with every doctor's help we cannot help but improve our Public Relations. This we must do if we are to continue to improve high quality medical care in the United States.



ARTHUR V. DUDLEY, JR., M.D.
PRESIDENT

DEPARTMENT OF COMMUNITY MEDICINE – PART II

The establishment of a Neighborhood Health Center in Tucson would undoubtedly take away a portion of the out-patient load at the Pima County General Hospital. However, our Neighborhood Health Center would be a general clinic rather than a set of specialty clinics. The latter are more important to the department heads and to the residency training program at the Pima County General Hospital. The Center would serve a clearly circumscribed population group by providing all day and all night coverage for that group of patients. This will give the medical student an opportunity to see how illness first appears; learn about the general setting from which the patient comes and understand better some of the underlying circumstances that may have precipitated the appearance of the illness. The Health Center will also provide a superb environment for residency training in Family Practice. A residency training program in this setting, away from the University Hospital, will make it possible to treat the subject of family medicine independently, without making it compete directly with some of the narrower specialties.

In addition to the educational and service opportunities of the Center, experience in the distribution of health services will make it possible to conduct research in this field. For example, if it is possible to use the Center to keep persons from entering the hospital, then it can surely be demonstrated that this method of patient management will cost less, on a per capita basis, than other systems.

The Neighborhood Health Center will have full-fledged representation inside the Medical School through a Department of Community Medicine. This Department will be an outgrowth of the more traditional Department of Preventive Medicine and Public Health but it will also encompass the problems that relate to the distribution of health services, with particular emphasis on the means that are available to the individual patient to gain entry into the health-care system. To head our Department of Community Medicine we have attracted to our campus Dr. Herbert K. Abrams, who came to us from the position of Professor and Chairman

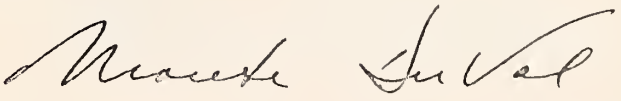
Dean's Page

of the Department of Preventive Medicine and Community Health at the Chicago Medical School.

Dr. Abrams was born in Chicago in 1913. He received his Bachelor's Degree from Northwestern University and his M.D. and Master of Science Degrees from the University of Illinois College of Medicine. Following an internship at the Cook County Hospital in Chicago, he undertook work toward the Master's Degree in Public Health, which he received from Johns Hopkins University in 1947.

Dr. Abrams has served as a Commissioned Officer with the U.S. Public Health Service; his primary activities being in the field of epidemiology and public health administration. He was also Chief of the Bureau of Adult Health in the California State Health Department. He has served as Chairman of the Industrial Hygiene Section of the American Public Health Association; and as a member and Keynoter for the Industrial Health Panel of the President's Commission on Health Needs of the Nation. He was a member of the Executive Board of the Health Division of the Welfare Council of Metropolitan Chicago. Recently, while at the Chicago Medical School, Dr. Abrams earned recognition for his role as Project Director of the Lawndale Neighborhood Family Health Center in South Chicago. Dr. Abrams is the author of a number of publications on Workmen's Compensation, Occupational Health Hazards, Collective Bargaining for Health, and the promotion of health in the work environment. Dr. Abrams is married and has three children.

The establishment of a Department of Community Medicine to operate a Neighborhood Health Center as a vehicle for undergraduate instruction in a medical school is an innovation in American medical education. We have great confidence in the ability of Dr. Abrams to bring to this program a soundness and a breadth that will stimulate additional thinking regarding the distribution of health services over the next decade or two.



Parking Lot



William B. McGrath, M.D.

Consider the sordaria, dung-inhabiting fungi with scattered, hairy-necked perithecia and dark, continuous ascospores. It is rumored that their intercurrent canals lead directly to the paragaster. Imagine that! Makes you think of the executive committee, doesn't it?

The doctors scurry out the back door of the hospital on their way to the parking lot. A couple clinical psychologists are murmuring their litany, starting every sentence, "In terms of — ." The one who is responding will keep his pipe tilted a few degrees upward even when he nods. Psychologists never look down for fear that you-know-what might be missing.

Internists look well-fed and urbane. Their ties and collars fit neatly, and if they are Grade Triple A, board certified, their shirt tails never billow out. They have very little hair on the backs of their hands, and even at the end of the day they are nearly odorless. When they gave way to psychiatrists as soothsayers, they took to telling long, dismal jokes without changing their serious expressions. In making a diagnosis they are in the dark until someone turns on the electrolytes. (Oh, that's a good one!)

Surgeons are not as polite as physicians. They run around in those loose green pyjamas and they refuse to look sneaky even when they pass flatus. Their humor is obscene, earthy, and they laugh out loud. Orthopedic surgeons dictate dry and flaky English, like the bits of plaster of paris on their forearms. In medical school they wenched a lot and many of them are illiterate. They

like to hunt and fish.

Pediatricians develop a scrotal appearance, wrinkling their foreheads with a displaced cremasteric reflex. They tend to favor either little toy cars or big ugly trucks. Obstetricians finally get fat bellies, a form of pseudocyesis, and the bosoms of their nurses are dry and collapsed.

Psychiatrists have a deceptively open look about them. They never breathe through their mouths or put their hands in their pockets or answer the telephone. If they were not afraid of being recognized they would go to dirty movies. Normal people and animals instinctively dislike them. Psychiatrists are secretly ashamed of their specialty; and since they don't do anything, they can't justify their fees. So they busy themselves "upgrading the general practitioner." If anyone suggested that the head-shrinkers might take a refresher course in general medicine, they'd wet their pants.

General practitioners are round-shouldered and nervous. They skitter sideways like crabs at the approach of relatives. House doctors ignore them, but the nurses are friendly and protective and will sometimes even mate with them. They save stacks of pamphlets and journals and they let the detail men in to see them. Because they take so many postgraduate courses the seats of their trousers get shiny!

There has been some concern about a power struggle between the general practitioner and the specialist. No: don't worry about it. The final decisive conflict, Armageddon, will be fought by receptionists. One gets our office on the phone and orders, "Please hold for Dr. Snurp." Meanwhile Dr. Snurp is finishing a physical examination or tinkling in his private sink. Our snippy secretary retaliates: "Well, I won't buzz our doctor until you have your doctor on the phone." It is a case of one-upsmanship, or one might say, one-upswomanship — but that sounds kind of indelicate.

The doctors hurry by one another, coming to and from the parking lot, and they look as grim and hymenopterous as ants passing on the edge of a sidewalk. I smiled and said "good evening" to one of the interns or residents. Golly, I didn't mean any disrespect. But his curt nod and pained little fissure-like grimace let me know how he is learning to guard his sacred person. He will eventually become a journeyman obnox. Any civility, any courtesy, must be saved for the patients — or for the relatives who are paying the bill. On the ward, when I asked the whereabouts of a patient, the nurse did not identify me as a consultant, a dues-paying member of the priesthood. She charged to the end of her leash (charge nurse, you know): "Sir, can't you see that we're busy?"

Yes, we're busy. And God only knows our unremitting fear that we'll make a mistake, do something or fail to do something, and cause suffering or death in someone who has put his trust in us. But we should be reminded to distinguish between taking our work seriously and taking ourselves too seriously. A little friendliness, a little graciousness, adds more to our professional stature than a forty dollar pair of shoes.

WHAT DO *I* GET FOR MY DUES?

A Bird's-Eye View of Your Association

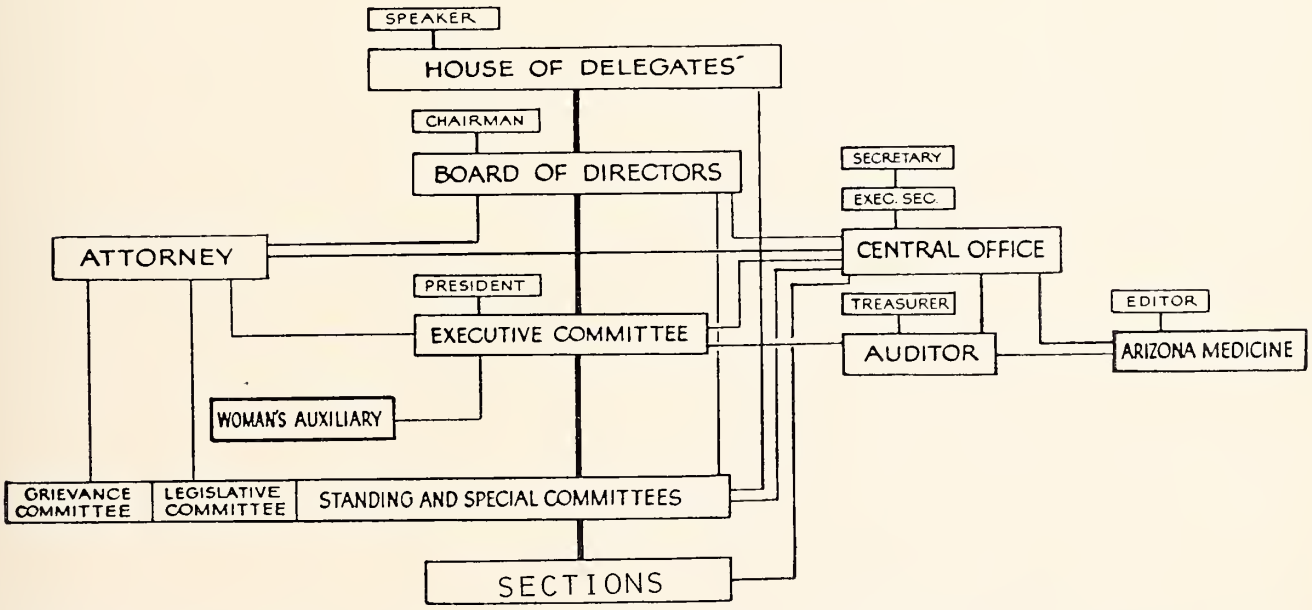
The officer of a State medical association hears no more troubling question than that often shot at him by an uninformed member: "What do I get for my dues?" Inquiry may shade into accusation: "I don't see that I receive any benefits from the $105.00 I pay every year to the Arizona Medical Association" (ArMA). To anyone who has participated in the work of our Association, the question is at once so unexpected as to take away the breath of an answer. However, when one marshals a defense of facts and figures, the reply to the detractor quickly passes from justification and explanation to certain pointed queries of the inquirer, as suggested in the peroration of this essay. To any fair-minded critic, it can readily be demonstrated that the exertions of the State medical association in behalf of its physicians are not far short of prodigious.

For those who are not conversant with the structure and operations of our organization, a summary may be a helpful backdrop for the description of its performance. The ultimate authority of ArMA is its House of Delegates, democratically chosen by the physicians of Arizona through their county societies. Between meetings of the House, the Board of Directors, whose members have all been elected by the House, by explicit sanction of the bylaws has the full power of that body to manage our affairs. The collation of facts and the preparation of policy alternatives for decision by the Board of Directors is the main function of the Executive Committee, which consists of the six executive officers of the Association. The grist that comes through the Executive Committee to the Board of Directors derives largely from committee study of problems and recommendations

for action. The bylaws provide for standing committees, and the President, with the approval of the Board, may appoint ad hoc committees for the consideration of special or unusual issues. The committees themselves have the prerogative of establishing sections for intensive examination of specific sectors of their responsibilities. The ladder of policy, therefore, ascends from section to committee to Executive Committee to Board of Directors to House of Delegates. At each Annual Meeting the Board, the officers, and all the committees furnish complete reports of their year's stewardship for the verdict of the House and for ratification if approved. Serving every echelon of Association business is the Central Office, together with its subsidiaries, our auditor and our attorney. Four ancillary establishments, *Arizona Medicine*, the Woman's Auxiliary, The Arizona Medical Association Foundation, and ArMPAC, operate autonomously but always within the limits set by ArMA and in undeviating accordance with its wishes and official program.

This circuit diagram of our Association is not difficult to trace. The communications that continually pass over it and represent the work for which it was designed can present a bewildering pattern. Perhaps it is easiest to follow from the output point of the Central Office, through which flows the day by day activity of the Association.

The Arizona Medical Association, Inc.
ORGANIZATION CHART



The average member cannot easily visualize the tremendous job done in his interest, directly or indirectly, through the Central Office and demanding the detailed attention of its small staff. The Central Office staff consists of our Executive Secretary and his assistant, and five stenographer-secretaries. We have in Robert Carpenter a fine executive secretary. In his assistant, Bruce E. Robinson, we are seasoning his replacement for the day of Mr. Carpenter's retirement in December '69. The Central Office staff has the task of serving over 1,500 physicians. At the time this article was prepared, the roster of the Association totaled 1,574: 1,378 active members, 14 Fifty Year Club members, 15 Seventy Year members, 95 associate members, 65 service members, and 7 affiliate members.

In addition to services provided each individual member and the faithful representation of the united viewpoint of Arizona's doctors, it should be recognized that the amount of work done by the Central Office in the routine administration of this major corporation is in itself immense.

Reviewing merely the procedures in connection with our expenditures, purchase of equipment and supplies, and the accounting therefor,

reveals them to be, as presumably they are in any corporation, a sizable charge. The recording of the proceedings of the House of Delegates, the Board of Directors, and the various committees of the Association is another assignment of unexpected magnitude. All of this entails a substantial volume of correspondence in preparation of meetings, the development of agendas, and the implementation of the determinations reached. A hint if not a detailed evaluation of the work of each of the committees of the Association will be given in a moment. The point here is that every one of these committees is enterprising and aggressive and preempts, entirely fittingly, a great deal of Central Office time. The Executive Secretary and his Assistant attend all committee meetings, which are usually held on a Sunday. Each committee and many of the sections requisition the attention of the Central Office. The staff furthermore handles the business and financial activities of *Arizona Medicine.*

A vital and sensitive role is the political one, advice to and support of the Legislative Committee; during the meeting of the Legislature, the staff is on constant call at the Capitol Building in the advocacy of our interests, largely before committees of the Senate and House of Representatives. In this the staff and counsel act to inform and assist the Chairman of the Legislative Committee and the officers of the Association.

Equal time is demanded of the Central Office by our Public Relations Committee; not only is constant vigilance necessary to inspect the information on health being dispensed by the organs of public information and the image of the physician they project, but also co-operation with press, radio and television is essential to furnish accurate stories on advances in medical science and the ways in which they will be made available to the citizens of Arizona. The Central Office, as clearing house for the Committee, in addition must meet the requests of many paramedical and non-medical agencies for speakers, exhibits, and information.

Finally, the Scientific Assembly Committee claims the concentrated attention of the staff each spring in the preparation of the program of Annual Meeting, which is after all the great professional observance of the Association. The Central Office people particularly have the chore of making all of the dispositions at the hotel selected, contacting and negotiating with exhibitors, and arranging the countless details of the convention, details the complexity of which can be credited by no one who has not had the responsibility and dubious pleasure of supervising our annual meeting.

Statistics need not be boring; they can be fantastic. The bare facts of the Association's epistolary production may convince the most dedicated skeptic that our staff is not exactly loafing. Every year the Central Office uses more than 30,000 letterheads, 10,000 second sheets and 40,000 copy sheets; 40,000 envelopes, and 100,000 sheet of Xerox copy paper. We have estimated that out of the Central Office go 14 letters per stenographer per day, 5 days a week, 52 weeks a year. This is routine correspondence, but each letter must be dictated and each one has significance in that it carries the weight of the Association's name and opinion. There is no need to multiply examples.

Any member who wishes reasonably to assess the uses to which his dues are put should have at least general knowledge of the expenditures of ArMA. For an itemized account, the Annual Report of the Treasurer is presented to the House of Delegates at the spring convention. The budget for the following year is also submitted at that time. In round figures, here is the way your money is spent. This year (1968) we have an anticipated outlay of $202,989.00. Of this, $68,000 defrays salaries, the various taxes levied on those salaries, industrial insurance, and the Blue Cross-Blue Shield coverage for our employees. A $9,000 sum goes for travel and meeting expenses, $10,000 for legal expenses, and $28,000 for rent, telephone, printing, supplies, insurance and other expenses. It costs us $87,820 for the 57 Boards, Committees, Sections and Advisory Groups to function. It will be noted that none of the officers of the Association and none of the committee members are reimbursed in any way for the many hours they spend on your business, except for luncheons on the days of meetings. Occasionally, officers or official representatives who travel to important AMA or governmental assemblages in distant parts of the country are reimbursed for their travel expenses, but even this concession is held to a minimum. Any self-appointed watchdog can be sure that there is no extravagance; the Association's pennies are pinched till Mr. Lincoln is cyanotic.

Before one begins to count the ways in which

the Association serves the individual member, it is proper first to reflect on what the Articles of Incorporation call "the objects, purposes and powers of this corporation and the general nature of the business it proposes to transact." Article III sets the tone: "to bring into one organization the entire medical profession of the State of Arizona; to promote the science and art of medicine; to promote and elevate the standards of medical ethics and medical education; to promote public health and in all instances and manners to operate as a non-profit business league and scientific and educational organization for the above-stated purposes." It is clear that the writers of what is truly our constitutional sanction were concerned with the employment of our collective energies in behalf of the public rather than narrowly in behalf of the economic gain of the individual doctor; and on two occasions the House of Delegates without dissenting vote has ratified the declaration. In following this sweeping injunction, however, the Association affords many very direct benefits to the individual physician. First of all, some of these may be listed as the most obvious answer to the question: "what do I get for my dues?"

Certain personal advantages are of an immediate economic nature, advantages that could not be found objectionable by the severest social critic of medicine. Among such is our placement bureau, which monthly tabulates opportunities for physician location throughout the State and answers inquiries about rural and urban opportunities. A second business service are the various insurance programs offered by ArMA. The guardianship of professional standards in the struggles with various private and governmental agencies that continually press for fixed fee schedules are other examples of its advocacy of the member's vocational interest. Through its Benevolent and Loan Fund ArMA stands ready to assist any physician who is in financial distress, through direct grants from the income of the fund. Personal good, if not measurable economic good, results from the Association's preservation of the history of medicine in Arizona, our piece in the great fabric of the tradition of our art, and from its maintenance, in the Central Office, of a record of each man's station in organized medicine. This includes a biography, current changes in professional situation and report thereon to AMA, an addressograph plate, and a comprehensive file card. Finally, it will mournfully provide his obituary.

Of less evident monetary value to the physician but still in the category of direct individual benefits are several other ArMA functions. It represents the doctor, as he could not be represented alone, with the Legislature, the American Medical Association, various lay organizations, and the public. Often these are stands of clear ultimate consequence for the member's community status and professional and economic well-being. Second, the Association also acts as an avenue of continued education for the physician, through the Annual Meeting, through seminars and special courses, through sponsorship of a State medical journal. *Arizona Medicine,* furthermore, furnishes ready pages for any Arizona physician who has a scientific matter worthy of report or who requires the precedence of prompt publication. ArMA is also a source of information. The Central Office will break its collective neck to dig out data pertinent to medicine on the request of any member. It is in the constant process of collecting such intelligence from the press and from other sources of public record, from other groups in organized medicine, and from many paramedical and lay associations. Though it is no longer necessary for it financially to rally behind the doctor accused of malpractice, the Association is still his shield; its Grievance Committee is at the call of any member with a juridical or ethical problem. Through its Industrial Relations Committee, it protects him in his dealings with the Industrial Commission and the industrial employers of our State, and through the Medical Economics Committee and the Professional Committee respectively it extends assistance on questions of a business character or disputes of purely medical jurisdiction. Those physicians who have found it necessary to request the Association's help in such matters would never challenge the use of his dues. In all of these areas — professional, legislative, economic, legal — your State medical association is always alert for relevant information and especially for any threats to the conduct of private practice, with the single aim of giving the Arizona physician access to knowledge he needs for the competent management of his professional and personal affairs.

Lastly, no catalogue of personal benefits is complete without appreciation of the advantages that any individual in modern collective society derives from identification with an organization.

In our enormous and complex culture the individual voice is too often drowned out, but spoken through the megaphone of a recognized group it can carry far, can conceivably change the course of events, shake the old and introduce the new. This is one of the direct uses to which you can put your Association. This gathering in purposeful companies for various public enterprises is in the accepted tradition of the United States; in the early days of the Republic, De Tocqueville wrote admiringly in "Democracy in America" of our impulse to join voluntary societies. It is the intention and hope of the officers and directors of ArMA that the channels are being kept open through which any member may speak his piece with the correct conviction that he will be listened to and that the Association will be his amplifier should he by consent be the prophet of his peers.

More significant to the physician than the personal gains he secures through his medical association are the social and scientific riches that he and his fellows can give to the society in which they live. This altruistic element in the work of ArMA is the real heart of its reason for being. Perhaps first in rank of these philanthropic functions is insistence on professional competence in our fellows. Through close liaison with the Board of Medical Examiners, the Association labors to keep out unfit doctors, charlatans and cultists, not, as assumed occasionally in certain sectors of the press, to protect the economic position of a closed guild, but rather to protect the health of the people. In fact, acting for its members, ArMA vigorously encourages the entrance of new doctors onto the medical stage in our State. The Benevolent and Loan makes available scholarships and loans to assist worthy young residents of Arizona who wish to secure a medical education. Additionally, through its placement bureau, the Association helps new doctors to find sites for practice and thus stimulates the immigration of welcome fresh professional talent from the country over. Our suggestion to the Board of Regents of the university system that an investigation be made of the feasibility of an Arizona medical school has borne fruit in our College of Medicine which will furnish many physicians for the State. The Grievance Committee safeguards the citizen against malpractice by any physician and against unethical conduct by any physician. Nationally, medicine has been taunted with whitewashing the malefactors within its ranks; this is not true of Arizona.

For last is kept the prime function of the doctor, the promotion of the public health, which the Association fosters in more ways than can be counted. It proposes legislation that it believes necessary and supports good legislation proffered by others. And, to end the story, the Association's benefits to the individual members are equally beneficial to the individual patient. Such functions as keeping the doctor professionally abreast, publishing a journal, assisting the Industrial Commission, working out fee schedules, or placing physicians in rural practices are indisputably as much in the public interest as in the doctor's interest. For the future, ArMA is devising its own solutions for some of the social and economic problems that block the successful distribution of scientific medical care to all sectors of the populace. We are not satisfied to stand pat; we are anxious to meet every challenge and to give our fellow citizens the very best that we can, not only in individual care but also in broader health measures.

For all of this, your satisfaction in supporting medicine's corporation, your voice in the profession's policies, the individual benefits you receive and the social contributions you make, you pay about 28½c a day. For this yearly levy you not only purchase many personal services but you sustain an organization that provides at once a pedestal and a loud-speaker for you in making known your ideas and wishes in every area from public health to politics.

A very good case could be made for the opinion that this is the most economical $105.00 any doctor ever spends. What do you get for an equal amount if you take a few friends out for dinner or if you sneak inside your wife's favorite dress shop? Perhaps the right emphasis is not what the physician gets for his $105.00 but what he is accomplishing with it. Perhaps, when its members realize the encompassing work that their Association does for them in Arizona and when they foresee the potential for further service, they will insist through their representatives in the House of Delegates that their dues be raised. Then an enlarged staff can perform the functions of ArMA more expeditiously, more thoroughly, and in more telling detail, and Arizona's doctors can contribute increasingly to the development of the house of medicine in a demanding but stimulating future.

Medical History

How one relatively small author (female) can condense the medical and historical facts concerning about 150 abdominal surgeons over a span of more than 200 years into a book of 180 pages is hard to believe, but Audrey Stevens, known to us all, has done it — and done it well. The book is interesting, excellent reading and, knowing Audrey, historically correct. It is a "must" for physician-surgeon reading.

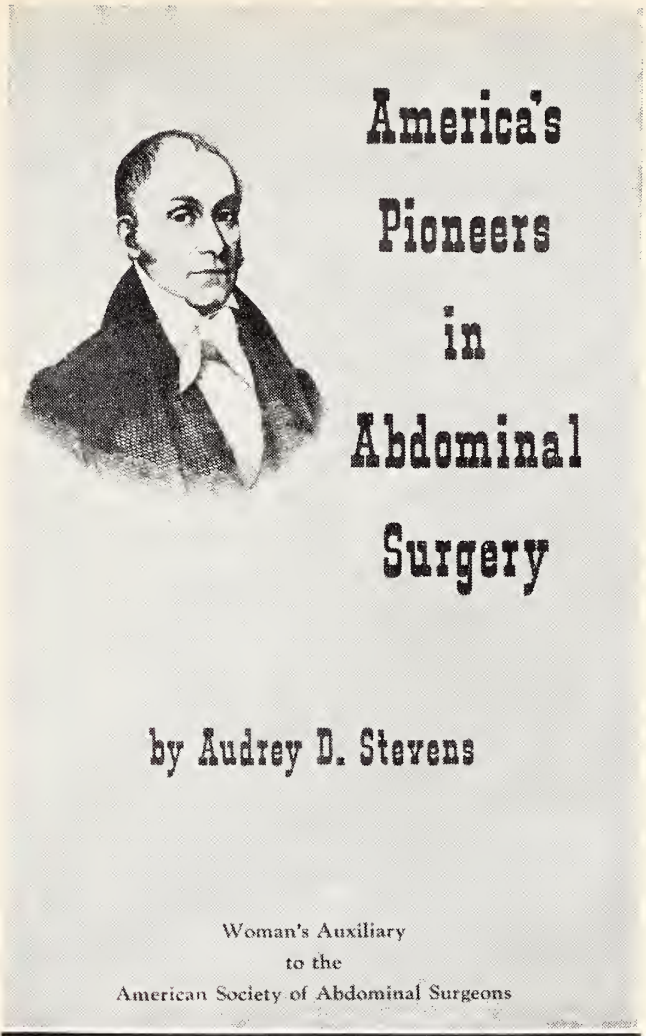
Six years ago Audrey Stevens, the wife of Dr. Weir C. Stevens of Kearny, Arizona, and now a member of the Board of Trustees of the Woman's Auxiliary of the American Society of Abdominal Surgeons by virtue of being a past president and having held every office in this organization, accepted a task of historical writing for this auxiliary. Prior to this time, from personal knowledge, she was not only actively engaged in an advisory capacity to our own "Medicine in Territorial Arizona," but was a regular contributor to *Arizona Medicine*. Now she presents the student of medicine and the student of medical history with a perfect little gem of a book — "America's Pioneers in Abdominal Surgery."

With names such as Halstead and Murphy to conjure with in addition to our own Doctors George Goodfellow and John Handy, the book omits none of the progenitors of abdominal surgery, and, in fact, dwells at some length as to their background and problems. The fee schedules are interesting, exhilarating, and very much mentionable. Stimulating questions will occur — the reader readily supplies his own answers.

To dwell more on the contents of the book would be to spoil the reading of the book. It is well organized, illustrated, and carries three main chapters with appropriate notes; appendices A, B, and C, and a bibliography and index.

Arizona Medicine salutes Audrey D. Stevens.

America's Pioneers in Abdominal Surgery by Audrey D. Stevens (American Society of Abdominal Surgeons), 180 pages — paperback — Acme Printing Company. Price $3.95.





Audrey D. Stevens

BOOK REVIEW

The Treatment of Venomous Bites and Stings

HERBERT L. STAHNKE, Ph.D.
DIRECTOR OF THE POISONOUS ANIMALS RESEARCH LABORATORY,
ARIZONA STATE UNIVERSITY

A familiar friend and no stranger to the physicians of Arizona has revised his 1958 First Edition of the treatment of venomous bites and stings and has presented for review an attractive pamphlet of some 117 pages dealing with the treatment of venomous bites and stings of the venomous animals in the animal kingdom, especially those found in the State of Arizona.

The pamphlet is divided into three chapters; the first one dealing with the extent of the venenation problem, and the second with preventive therapy especially with the objectives of venom control and the L-C technique, the technique of ligature and cryotherapy, ending the chapter with a critique of the L-C technique. Chapter Three deals exclusively with corrective therapy.

The pamphlet contains 107 references, three rather comprehensive tables and 21 illustrations. The references are impressive, the tables inclusive, and the illustrations completely satisfactory. It is this reviewer's impression that the Revised Edition contains much merit and should be read by every individual physician in Arizona, of all Clinics and Hospitals, possibly dealing with the admission of victims of venomous bites and stings.

The author clearly states that the L-C method should be used as the primary therapy in all cases of venenation, but that individual situations should be supported by other treatment.

With the author's permission, the L-C technique is summarized and reproduced for your evaluation.

THE L-C TECHNIQUE SUMMARIZED

1. Place a ligature (a tight tourniquet) at once between the site of the bite and the body, but as near the point of entrance of the venom as possible. Should the point of penetration be a finger or toe, place the ligature at the base of the digit.

2. Now place a piece of ice on the site while preparing a suitable vessel of crushed ice and water.

3. Place the member well above the point of ligation in the iced water. If the bite is in an area where this cannot be accomplished, pack the same area with finely crushed ice.

4. With the hand, arm, etc. in iced water (or finely divided ice) the ligature should never be removed in less than 5 minutes; preferably kept there for 10 or more minutes when the venomous animal is large; e.g. a gila monster, pit-viper snake, etc.

5. If the envenomized member is to be treated for more than four hours, finely divided ice should be used rather than iced water.

6. In the case of pit viper bite, after 24 hours, keep the patient warm to the point of perspiration, *while the ice is kept on the envenomed hand, arm, foot, etc.* If this step is excluded, tissue destruction eventually cannot be prevented.

7. When venom action has ceased, place the envenomed part of the body in iced water and allow the water to come normally to room temperature.

THINGS NOT TO DO

1. Do not wait to see whether anything will happen. This is foolhardy and is the way ordinarily simple envenation develops into a medical problem.

2. Do not stop to make cuts or attempt to suck out venom. This is wasting time dangerously. Remember the venom can enter the body in seconds. Get a ligature in place. Furthermore,

Arizona State University, Bureau of Publications, 56247, Arizona State University, Tempe, Arizona 85281. Price $1.50. Addenda: A brief summary to the L-C method per se is available by writing to: Poisonous Animals Research Laboratory, Arizona State University, Tempe, Arizona 85281. Single copy — 10c (quantity discounts available).

if any cutting is to be done, let the trained physician do this.

3. If the offending animal was not seen, do not stop to look for it. At least apply the ligature before the search is made. Or, if several members are in the party, let someone else do the searching.

4. Do not use hot packs. Heat dilates blood vessels and speeds up circulation. It also speeds up the chemical reactions.

5. Do not use any narcotic or epinephrine during the first 24 hours. These drugs increase the action of the venoms.

6. Do not excite the patient. Stress increases the venom toxicity.

7. Do not use the "hour on—hour off" method of refrigeration. This intensifies the pain and enables the venom to act.

8. Do not merely use ice bags. This will not prevent venom absorption or tissue destruction but can increase capillary fragility which may hasten tissue destruction.

SUPPORTING THERAPY

The L-C method should be used as the primary therapy in all cases of envenomization, but in some situations should be supported by antivenin, antibiotics, sedation, and maintenance of proper fluid balance of the body.

When antivenin is indicated, it should be given so as to get it into the body circulation rapidly. Injecting it around the site of the bite or sting is a waste of time and antivenin. The lethal effect of the venom will be in the body proper. The faster the antivenin gets there, the better. Also, failure to given enough antivenin may result in death.

Death can be caused by secondary effects, such as excessive swelling and infection.

Topics Of Current Medical Interest



Herbert Dozoretz, M.D., has been elected to the Board of Trustees of Good Samaritan Hospital. Dr. Dozoretz is chief of staff at Maryvale Hospital.

He is a graduate of Southwestern Medical School, University of Texas, and took residencies at Fordham Hospital, New York City, and the V.A. Hospital, Newington, Connecticut.

Dr. Dozoretz has been in active practice in Arizona since 1962.

AVAILABILITY OF THE PHYSICIAN-PATIENT PRIVILEGE

A doctor advises his patient that he is in poor health. The patient subsequently dies. May the doctor thereafter safely disclose that his patient knew of his poor state of health.

The proceeding in which the doctor is examined determines the certainty with which an answer to the above question can be given.

The doctor's duty not to answer is relatively certain if he is being examined: (1) as a witness in an Arizona court; (2) as a witness in a federal district court in Arizona; (3) in a discovery proceeding preliminary to a suit in either court; (4) informally (not in connection with present or pending litigation).

An Internal Revenue agent has the power to summon persons having knowledge relevant to the tax liability of any individual, and, pursuant to this power, might attempt to examine a physician regarding information usually considered privileged. Whether the doctor-patient privilege is available in such an investigation is unclear. To insure his safety, therefore, a doctor summoned by a Revenue agent should follow the course of action outlined below.

1. He should notify the personal representative of the deceased patient that a summons has been served, perhaps to obtain confidential information about the decedent.

2. The physician should appear for examination as directed by the summons. If the patient's estate has authorized the doctor to divulge privileged information he should do so. If the estate has not consented, the physician should refuse, on the ground of privilege, to answer questions calling for confidential information. The physician may neither be held in contempt nor fined for this refusal.

3. When the doctor refuses to answer on grounds of privilege, the only course available to the I.R.S. agent is to apply for a federal court order requiring that answers be given. When a hearing is held on this application the estate may assert the defense of privilege. If the defense fails and the doctor is ordered to answer, he should do so. For refusing to comply with this order the physician may be held in contempt.

DONALD FREDERICK DeMARSE, M.D.
1923-1968

An acute myocardial infarction on August 18th, 1968, marked the terminal event in the nineteen-year medical practice of Donald Frederick DeMarse in Arizona. He was forty-four years old on December 13th, 1967. Born and reared in Sioux Falls, South Dakota, he attended the University of Minnesota, receiving his doctorate there in 1947.

He demonstrated an insatiable curiosity early in his academic career about life and its creatures. The sublimation of this boundless inquisitiveness was represented in the record of academic excellence he achieved in the preclinical years and was manifest in his unusually keen application of scientific technique to the practice of general medicine. For those who were close to him, the enigma was posed in how a physician in a remote rural area where patient volume was so great, could remain not only dedicated to scientific principal, but, could ad lib, demonstrate to peer and patient alike, a penetrating knowledge of current medical thought and technique. He was a voracious reader of the medical literature, and through fatiguing diligence to that principal of "forever a student," he read daily and through the years accumulated a vast medical library.

Don's interest in and vast knowledge of anatomy, pathology and chemistry marked him early as a candidate for research or academic medicine. His need for people, however, exerted a greater force than his well disciplined scientific curiosity, and on completion in 1948, of an internship in St. Joseph's Hospital, in Phoenix, Arizona, he chose general surgery for the practical expression of his special interests. He completed one year of residency training, leaving St. Joseph's Hospital in 1949, to become an associate of the late Dr. Charles Ploussard. After two years in Phoenix, Arizona, he had the opportunity to enter general practice in Holbrook, Arizona, which he did in 1951, and remained in Holbrook until his death.

Here was a teacher, a man well read and well versed in scientific method, applying unmistakable scientific technique and discipline in a remote area of general practice, where less a man

would likely have yielded to the temptation of less than excellent service, and would have been satisfied with mediocre practicality. His perseverance won him honor among his peers. The new Holbrook Hospital in its complete adequacy and its superior equipment and his own medical facility reflect his guidance and the excellence on which he always insisted. Less insistence would have been acceptable, since no other medical standard was present. His love of Holbrook and its people sustained him when fatigue was overwhelming. His love of family and friends gave him purpose and direction when he faced the absence of professional colleagues. The blending of applied science with compassionate warmth for human want became the uniquely artful expression which was to characterize him. Don was active in the Arizona Medical Association, having served on its Board of Directors. He was a member of the American Academy of General Practice, as well as The American Association of Railway Surgeons, The American Geriatrics Society, and The Medical Society of the United States and Mexico. He was a retired officer in the Arizona National Guard.

He was honored in 1967 by the residents of Holbrook with a "Doctor DeMarse Day," a surprise which pleased him greatly, since he was a man who gave without expectation.

His contributions are marked in the minds and hearts of the thousands who came to him in illness. The seventeen hundred infants he delivered serve as living memorials. The people of Holbrook and its surrounding areas have been significantly influenced and stimulated by a scientist who found that unique way to teach through practical application. He left a standard of medical excellence difficult to emulate.

Don left a family of six, his wife, Corlyn; daughters, Corene, Carol and Karen; and sons, Martin and Corwin. The latter is a pre-medical student at Don's Alma Mater, Minnesota. Their grief will eventually end and the seemingly final nature of death will be replaced with an awakening spirit of hope which results from the phenomenon of healing and is sustained by reflections on the man's good works and deeds.

Robert J. Haley, M.D.

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anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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Future Medical Meetings

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Children's Hospital
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Leo Stern, M.D., Assistant Professor of Pediatrics, McGill University, will present a series of lectures in cardiopulmonary problems of the newborn.
No fee.

Write: Joseph Butterfield, M.D.
Denver Children's Hospital
19th Avenue at Downing
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AMERICAN MEDICAL TENNIS ASSOCIATION

1969 National Winter Tennis Tournament

February 12 through 15, 1969

Tucson, Arizona

(Headquarters Hotel: Statler Hilton Inn)

Deadline for entries: January 1, 1969

For further information contact:
Harold W. Kohl, M.D.
1002 North Country Club Road
Tucson, Arizona 85716

ARIZONA STATE PEDIATRIC SOCIETY

RAMADA INN
404 N. Freeway — 624-8341
Tucson,, Arizona

November 29, 1968 — Friday

1:00 p.m.—REGISTRATION

2:00 p.m.—Dr. Jack Wilson: "General approach to diagnosis of anemia in children"

2:40 p.m.—Dr. M. Eugene Lahey: "Treatment of iron deficiency — choice of compounds, economics"

3:15 p.m.—Coffee Break

3:30 p.m.—Case Presentations to 5:00 p.m.
Dr. Lahey, Dr. Wilson,
Dr. Johnson

November 30, 1968 — Saturday

8:00 a.m.—REGISTRATION

9:00 a.m.—Dr. Jack Wilson: "Milk anemia—What's in a name"

9:40 a.m.—Dr. M. Eugene Lahey: "Leukemias and malignancy in childhood"

10:15 a.m.—Coffee and Rolls

10:30 a.m.—Dr. Wm. Denny: "Erythropoietin levels in polycythemic syndrome"

11:10 a.m.—Questions for Panel:
Dr. Lahey, Dr. Wilson,
Dr. Denny

12:00 noon—Joint luncheon with American Society of Dentistry for Children—Arizona Section

1:00 p.m.—Panels (Joint Dental and Pediatric)
"Government Programs"
"Pediatric-Dental Problems"

3:00 p.m.—Business Meetings

Fee: $10.00



SCIENTIFIC PAPERS
SCIENTIFIC EXHIBITS

FOR THE 1969 ANNUAL MEETING OF THE ARIZONA MEDICAL ASSOCIATION

APRIL 22-26, 1969

PAPERS:

Again this year the Arizona Medical Associaion is soliciting papers from Arizona Physicians for presentation at our Annual Meeting in April 1969. We are particularly interested in papers dealing with the Medical and Surgical Sub-Specialties and in having the Directors of Medical Education in our state's hospitals encourage the participation of their Interns, Residents and Fellows. The papers should be approximately one-half hour in length.

A brief abstract must be mailed to:

Chairman — Scientific Assembly Committee
Arizona Medical Association
4601 North Scottsdale Road
Scottsdale, Arizona 85251

The deadline for consideration is December 1, 1968.

EXHIBITS:

If you have a Scientific Exhibit that you wish to show at the 1969 Annual Meeting, please forward a brief written description of the exhibit to:

Chairman — Scientific Assembly Committee
Arizona Medical Association
4601 North Scottsdale Road
Scottsdale, Arizona 85251

Scientific Exhibits are limited to booths with the following dimensions: 8' wide, 6' deep and 7' 6" high. Because of physical limitations, there can be no exceptions to these booth dimensions. The cash award provided in previous years will not be available this year. All applications for scientific exhibit space should be mailed by December 1, 1968.

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It is not in pleasure,
but in rest from pain."

John Dryden

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Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

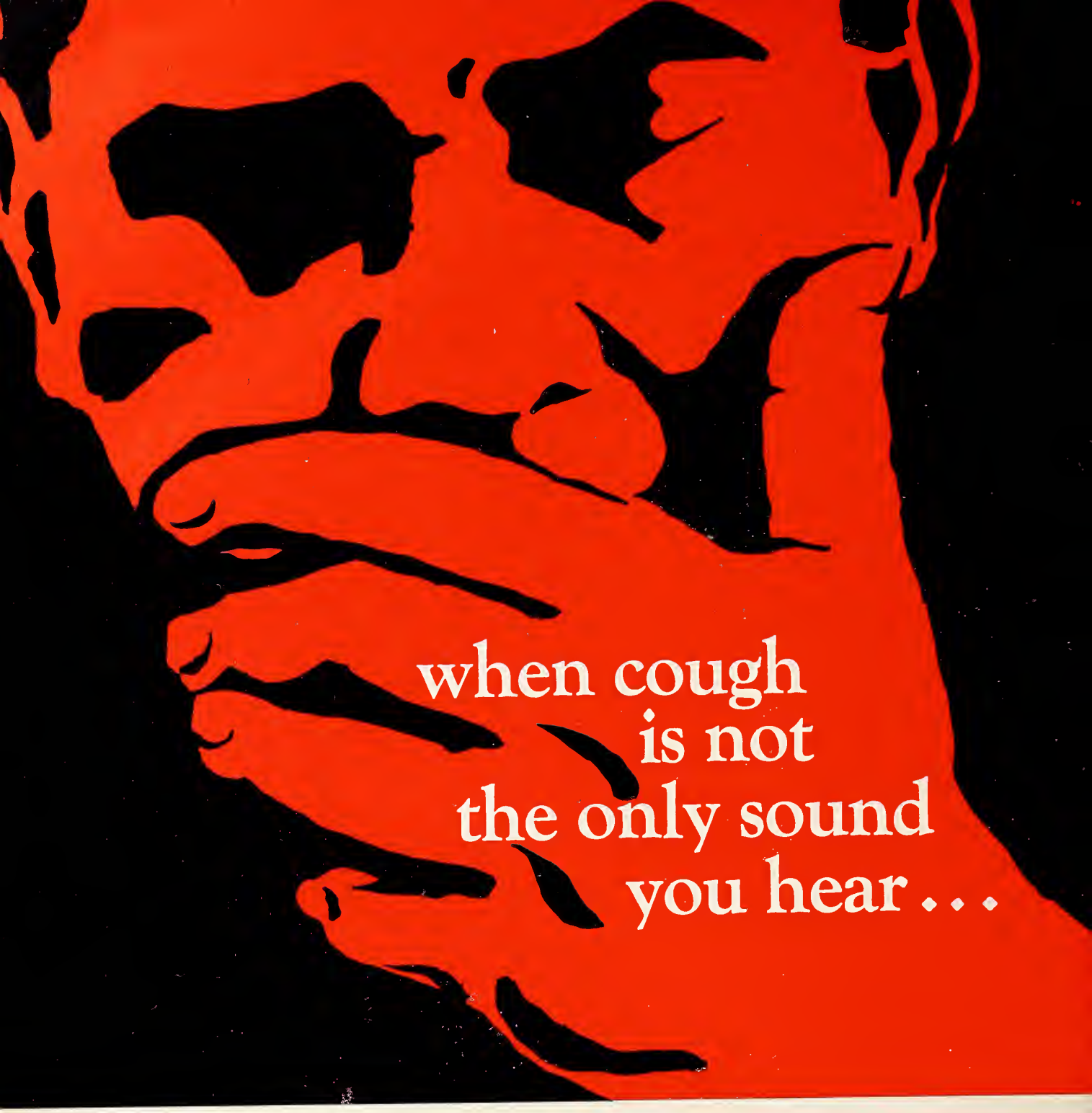
Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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ACHROMYCIN® V
TETRACYCLINE

Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

359-8

Suspected tetracycline-sensitive infection?

While waiting for the results of the sensitivity test, start the therapy likely to succeed...

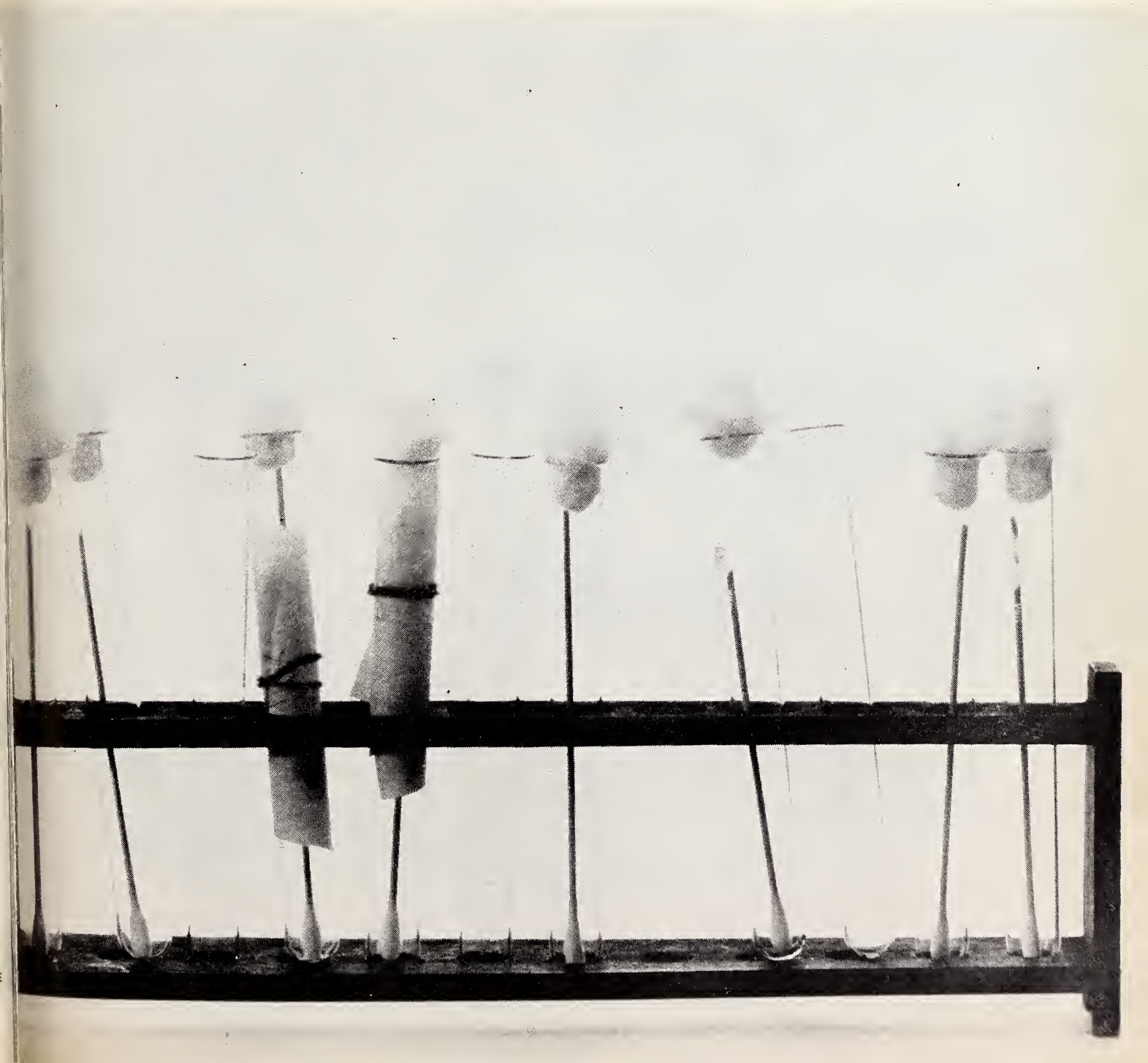
Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

←Prescribing Information

ACHROMYCIN® V
TETRACYCLINE
Lederle

The price differential is inconsequential.





sustained-release

Mol-Iron® Panhemic Chronosule®*

capsules

To help overcome the inadequacies of poor absorption and insipid diet common in the geriatric patient—a superior, sustained-release hematinic combined with key vitamins.

Each Mol-Iron Panhemic Chronosule capsule contains: Ferrous sulfate, 390 mg. (78 mg. elemental iron) and Molybdenum sesquioxide, 6 mg. in sustained-release form; Vitamin B_{12}, 25 mcg.; Vitamin B_1, 6 mg.; Vitamin B_2, 6 mg.; Vitamin B_6, 5 mg.; Niacinamide, 30 mg.; Vitamin C, 150 mg. Supplied: bottles of 30.

*brand of sustained-release capsule

†Parsons, P.L., Withey, J.L., and Kilpatrick, G.S : Practitioner 195:656, (Nov) 1965.

White Laboratories, Inc.
Kenilworth, N. J.

BETTER TOLERATED—HELPS ASSURE MORE PREDICTABLE ABSORPTION AND OPTIMAL HEMOGLOBIN RESPONSE

SUPERIOR TO CONVENTIONAL FERROUS SULFATE

In 'Toler-ability'

Slowly-liberated,molybdenized ferrous sulfate virtually eliminates gastrointestinal side effects.

So well tolerated it can be taken on an empty stomach.

In 'Absorb-ability'

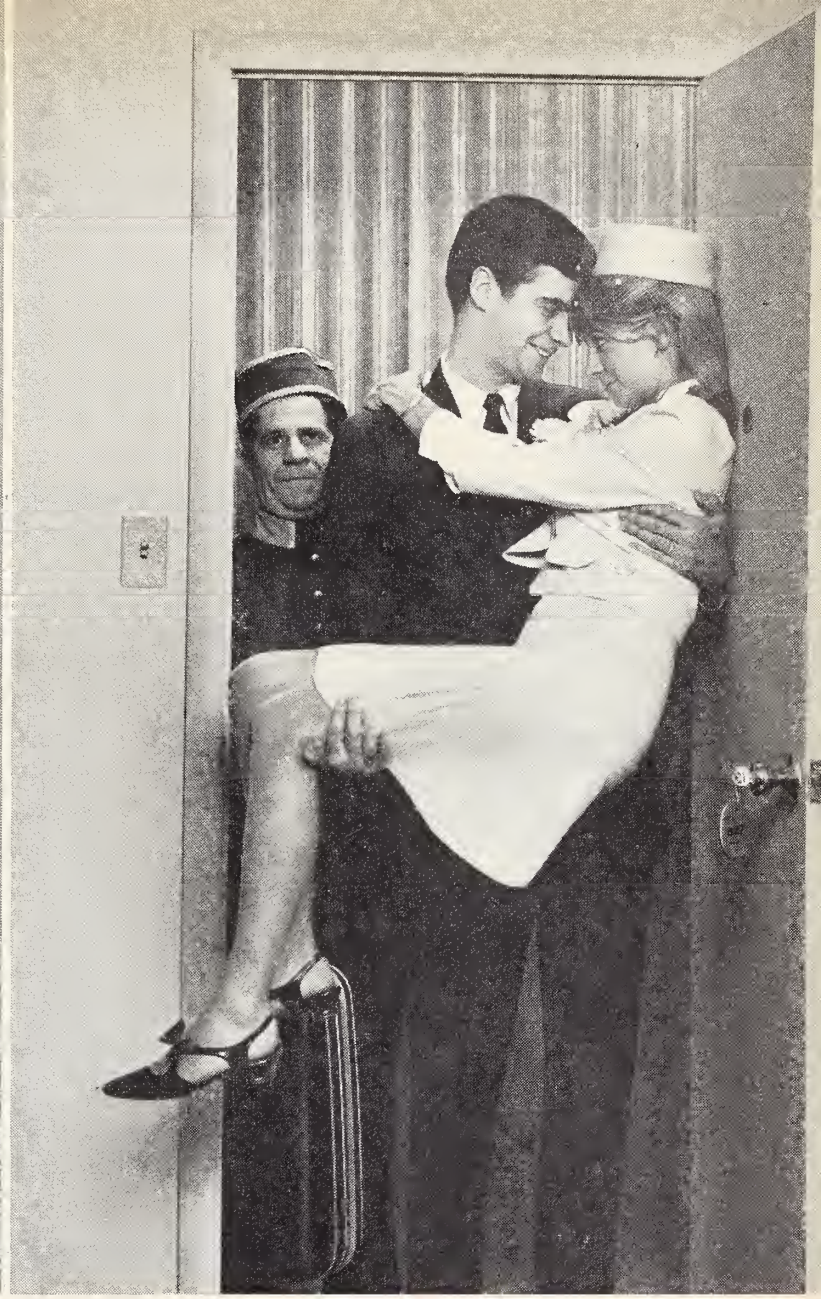
Gradual release of better tolerated, molybdenized ferrous sulfate helps assure more predictable absorption.

In 'Dose-ability'

Just a single Mol-Iron Panhemic Chronosule capsule daily generally corrects mild to moderate hematologic and nutritional deficiencies.



Picture of low back pain



treated with Parafon Forte® TABLETS

Paraflex® (chlorzoxazone)* 250 mg.
Tylenol® (acetaminophen) 300 mg.

Parafon Forte helps to relieve pain, restore mobility...stop pain-spasm feedback

Here is why. PARAFON FORTE provides:

a nonsalicylate analgesic equal to aspirin for the relief of pain,[1,2] yet unlikely to produce the irritation to the gastric mucosa so often associated with salicylate therapy[3]

and a skeletal muscle relaxant shown to have up to a 6-hour span of action[4]...to retain effectiveness even on continued administration[4]...but not likely to have the central effects of tranquilizing compounds.[5]

Prescribe PARAFON FORTE for effective spasmolysis and analgesia in sprains, strains, myalgias, low back pain, bursitis and other musculoskeletal disorders. Your patients will appreciate the restored comfort and freedom of movement it usually provides.

Contraindications: Sensitivity to either component. ***Precautions:*** Exercise caution in patients with known allergies or history of drug allergies. If a sensitivity reaction or signs or symptoms suggestive of liver dysfunction are observed, the drug should be stopped. ***Adverse Reactions:*** Occasionally, drowsiness, dizziness, lightheadedness, malaise, overstimulation or gastrointestinal disturbances may be noted; rarely, allergic-type skin rashes, petechiae, ecchymoses, angioneurotic edema or anaphylactic reactions. In rare instances, *Paraflex* (chlorzoxazone) may possibly have been associated with gastrointestinal bleeding. While *Paraflex* (chlorzoxazone) and chlorzoxazone-containing products have been suspected as being the cause of hepatic toxicity in approximately eighteen patients, it was not possible to state that the dysfunction was or was not drug induced. ***Usual Adult Dosage:*** Two tablets q.i.d. ***Supplied:*** Scored, light green tablets, imprinted "McNEIL"—bottles of 100.

References: 1. Batterman, R. C., and Grossman, A. J.: Fed. Proc. *14*:316, 1955. 2. Goodman, L. S., and Gilman, A., ed.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Company, 1965, p. 331. 3. Roth, J. L. A., *et al.*: Gastroenterology *44*:146, 1963. 4. Berman, H. H., *et al.*: Dis. Nerv. Syst. *25*:430, 1964. 5. Friend, D. G.: Clin. Pharmacol. Ther. *5*:871, 1964.

*U.S. PATENT NO. 2,895,877

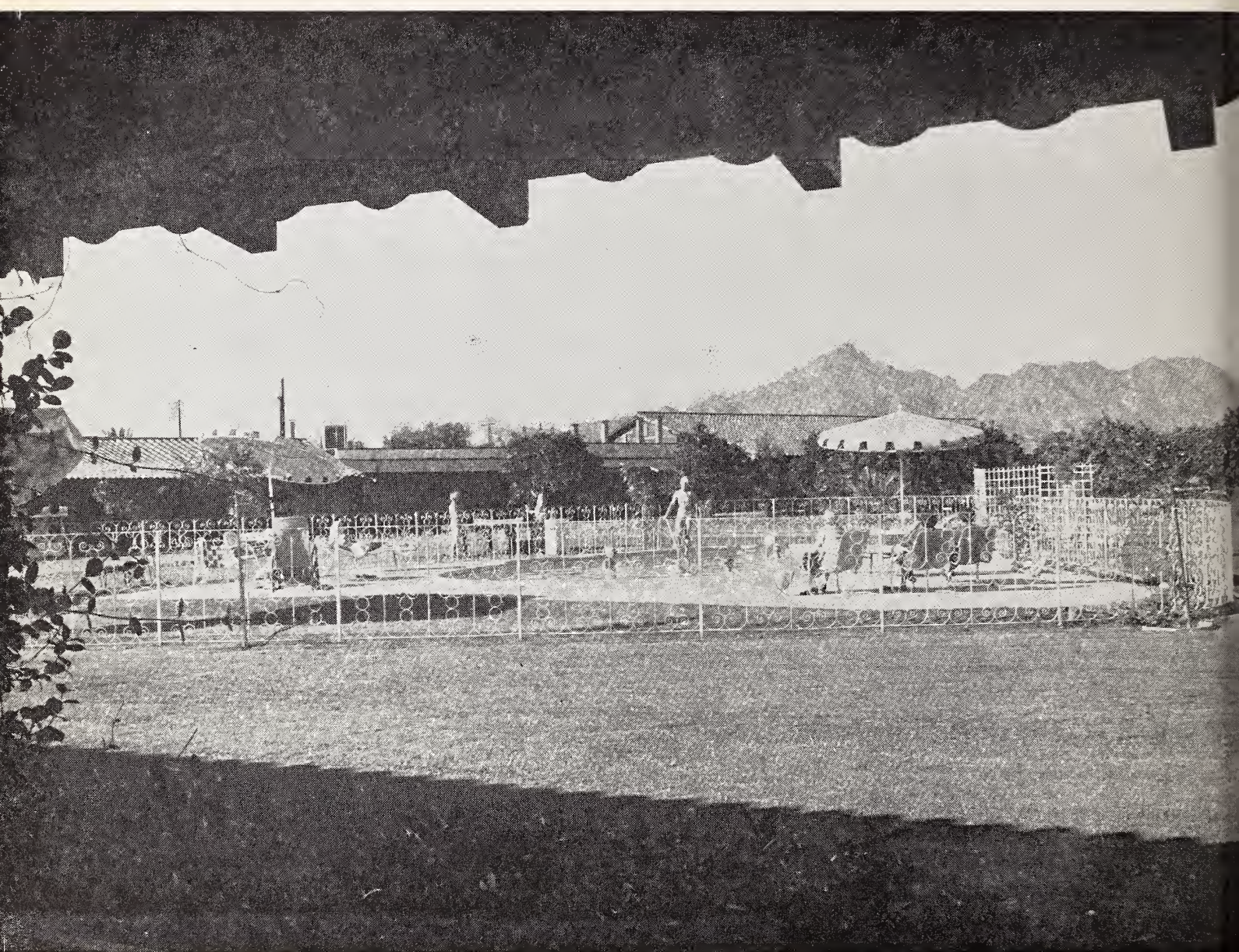
McNEIL

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Located in the heart of the beautiful Phoenix citrus area near picturesque Camelback Mountain, this hospital is dedicated exclusively to t treatment of psychiatric and psychosomatic disorders, including alcoholism.

Facilities include:

- ☆ Spacious, year 'round outdoor recreation area
- ☆ Heated swimming pool
- ☆ Modern, comfortable rooms



- Open medical staff • 91 bed capacity
- Ratio of more than one registered staff nurse to every two patients
- All rooms air-conditioned • Spacious grounds cover ten acres
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 Association of Western Hospitals
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- Approved by:
 The Joint Commission on Accreditation of Hospitals and The American Psychiatric Association

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PLUS $1,000 INSURANCE PROTECTION FOR ONE $50 PAYMENT



HBA'S DESIGNOLIFE YOUTH ESTATE designed to create habits of thrift and responsibility.

Age 0 to 15½ — New Designolife Youth Estate Plan provides lifetime insurance protection. One payment of $50 pays for $1,000 insurance up to age 23.

Automatically increases to $5,000 at age 23 with annual premium of only $75 until age 65.

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Pays $3450 cash at age 65 or a paid-up policy for $5,000.

Designed to protect the child's estate in years to come and to encourage the habit of thrift. A wonderful gift for now and the future!

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When she gets a bacterial infection, think of Tetrex-F®

Like the debilitated or diabetic patient, she may be susceptible to monilial overgrowth.

That's why she needs the extra protection of Tetrex-F whenever tetracycline therapy is indicated. Tetrex-F provides well-tolerated tetracycline phosphate complex for the bacterial infection—nystatin to help prevent monilial overgrowth.

Tetrex-F®

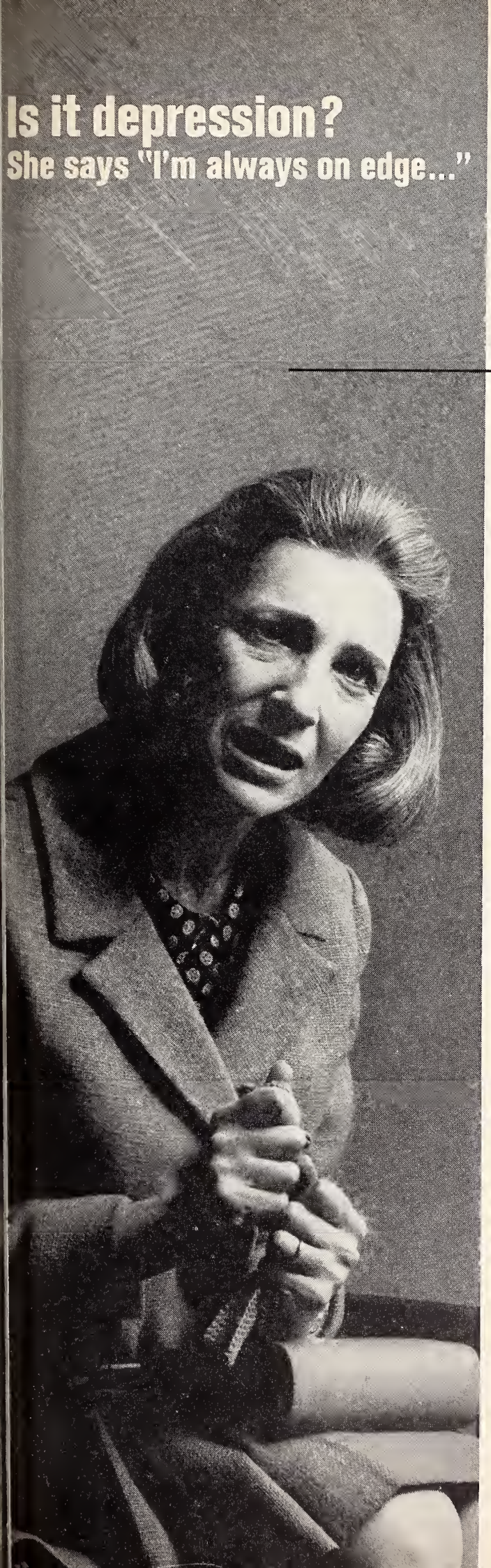
(tetracycline phosphate complex-nystatin)

Whenever monilia may threaten tetracycline therapy

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A. H. F. S. Category 8:12**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201



Is it depression?
She says "I'm always on edge..."

...but her other symptoms:
depressed mood, insomnia, anorexia, feelings of guilt
strongly suggest an underlying depression.

when the diagnosis is depression

ELAVIL® HCl
(AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

MERCK SHARP & DOHME Division of Merck & Co. Inc. West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

In peptic ulcer: the antacid puzzle



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

Medical Center X-Ray and Clinical Laboratory

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Phone ALpine 8-3484

DIAGNOSTIC X-RAY

CLINICAL PATHOLOGY — TISSUE PATHOLOGY

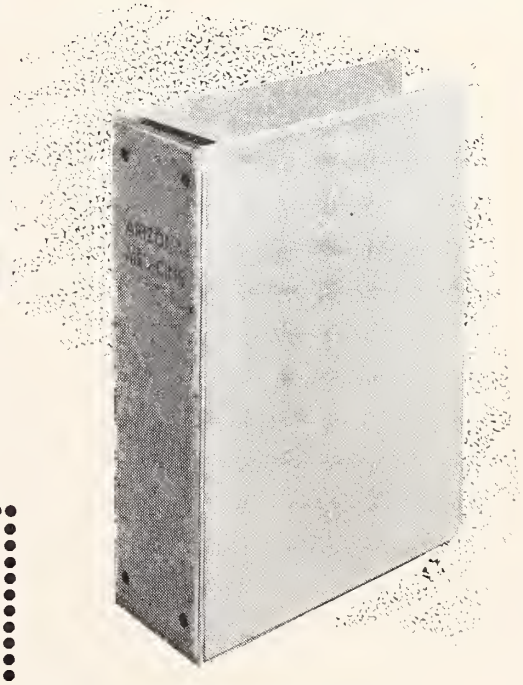
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He isn't burdened by his hypertension or his therapy...



Butiserpazide® lowers blood pressure so smoothly that patients are often untroubled by either the disease...or treatment

BUTISERPAZIDE provides not only the classic thiazide/reserpine formula; it supplements it with the mildly sedative effect of BUTISOL (butabarbital).

Clinical comparisons have shown that many patients respond to this treatment with (1) smooth, uniform lowering of blood pressure[1]...at times *below* the levels attained with previous therapy[2]; (2) "striking" improvement in such symptoms as headache, nervousness, palpitation and dizziness[2]; plus (3) "...lowered incidence of drug side effects."[2]

And BUTISERPAZIDE offers an added advantage: the usual dosage is just 1 tablet once or twice daily. It is available in two strengths for dosage flexibility.

Are there any hypertensives in *your* practice who might find life a little pleasanter on BUTISERPAZIDE?

Contraindications: Sensitivity to any component, porphyria, peptic ulcer, ulcerative colitis, mental depression, renal impairment or shutdown. **Warnings:** Consider the possibility of sensitivity reactions in patients with history of allergy or bronchial asthma. Coated potassium tablets, sometimes administered in conjunction with antihypertensive therapy, may be associated with small bowel lesions, which have led to obstruction, hemorrhage and perforation. Surgery has frequently been required and deaths have occurred. Such tablets should be used only when indicated and when adequate dietary supplementation is not practical. They should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occur. *Use in Pregnancy:* Exercise caution, since thiazides cross the placental barrier and may cause fetal or neonatal hyperbilirubinemia, thrombocytopenia or altered carbohydrate metabolism; adverse reactions seen in the adult may occur in the newborn. Use reserpine in women of child-bearing age only when essential to patient welfare. Increased respiratory secretions, nasal congestion, cyanosis, and anorexia may occur in infants born to reserpine-treated mothers. **Precautions:** *Butisol* (butabarbital)—Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression. *Hydrochlorothiazide*—May induce electrolyte imbalance; when used with digitalis or one of its glycosides and in patients with severe hepatic insufficiency, cardiac arrhythmias or symptoms of impending hepatic coma may occur. Discontinue and institute appropriate countermeasures if prolonged use produces hypokalemia or (likely with sodium restriction) hyponatremia and hypochloremic alkalosis. (Ammonium chloride, used to reverse hypochloremic alkalosis, is contraindicated in hepatic disease.) May produce elevated serum uric acid levels (and, infrequently, gout) or reduce glucose tolerance, altering insulin requirements in diabetics. *Reserpine*—Observe for signs or symptoms of peptic ulcer or ulcerative colitis. Discontinue at first sign of mental depression; keep in mind possibility of suicide. Exercise extreme caution in history of mental depression. May produce cardiac arrhythmias when used with digitalis and quinidine, or may precipitate biliary colic in patients with gallstones. Discontinue 1 to 2 weeks before surgery; inform the anesthetist in event of emergency surgery. Exercise caution in history of epilepsy. Discontinue 1 to 2 weeks before ECT. *General*—Exercise caution in coronary artery disease. **Adverse Reactions:** Dizziness, drowsiness, weakness, nasal congestion, leg cramps, nausea, palpitations, superficial skin bruises, palmar erythema, headache, dehydration, skin rash, "hangover," systemic disturbances, diarrhea, itching, vomiting, paresthesia, photosensitivity, pancreatitis, jaundice, xanthopsia, purpura, thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia, anorexia, gastric irritation, abdominal cramping, constipation, glycosuria, vertigo, cutaneous vasculitis, orthostatic hypotension (potentiated by alcohol, barbiturates, or narcotics), increased salivation and gastric secretion, increased intestinal motility, loose stools, angina-like syndrome, arrhythmias, bradycardia, flushing, hypotension, nervousness, paradoxical anxiety, rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, optic atrophy), dryness of mouth, syncope, epistaxis, weight gain, and impotence or decreased libido. **Usual Adult Dosage:** BUTISERPAZIDE®-25 or BUTISERPAZIDE®-50: 1 tablet daily or b.i.d. When used with other antihypertensive agents reduce dosage of both drugs about 50% and observe carefully for changes in blood pressure. ***Before prescribing or administering, see package insert.*** **References: 1.** Johnson, H. J., Jr.: Penna. M. J. **67**:35, 1964. **2.** Coodley, E. L.: Curr. Ther. Res. 4:460, 1962.

Butiserpazide®-25

PRESTABS®* Tablets

BUTISOL® (butabarbital) 30 mg.†; Hydrochlorothiazide 25 mg.; Reserpine 0.1 mg.

Butiserpazide®-50

PRESTABS®* Tablets

BUTISOL® (butabarbital) 30 mg.†; Hydrochlorothiazide 50 mg.; Reserpine 0.1 mg.

†**Warning:** May be habit forming.

*15 mg. of **Butisol** (butabarbital), plus the other ingredients, in outer layer; 15 mg. of **Butisol** (butabarbital) in a specially coated core for delayed release, to approximately equalize duration of action for all components.

McNEIL

McNEIL LABORATORIES, INC.
FORT WASHINGTON, PA.



One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin (2½ grains) 162 mg.
Kaolin (specially purified) (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

ROERER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

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A School For Exceptional Children

The Hobby Horse Ranch School is both home and school for a small group of children. It welcomes the child who is mentally retarded and physically handicapped as well as the backward child who suffers no physical handicap.

The Hobby Horse Ranch School is a branch of Fairview School in Fishkill, New York which was established in 1936.

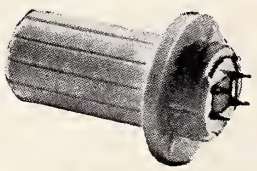
Directors: Blanche C. Lightowler, B.A.
Matthew W. Lightowler

P.O.B. 44, Cortaro, Ariz.

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST

(Rosenthal)

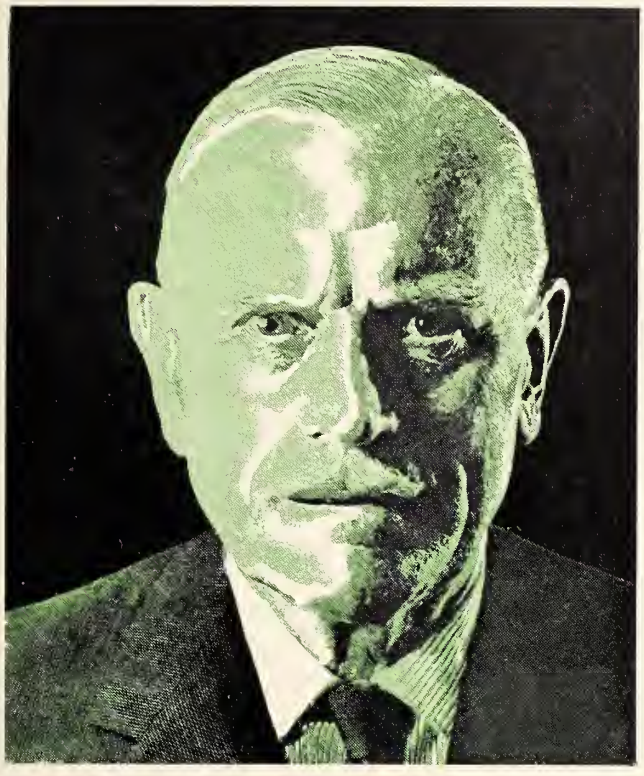
The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

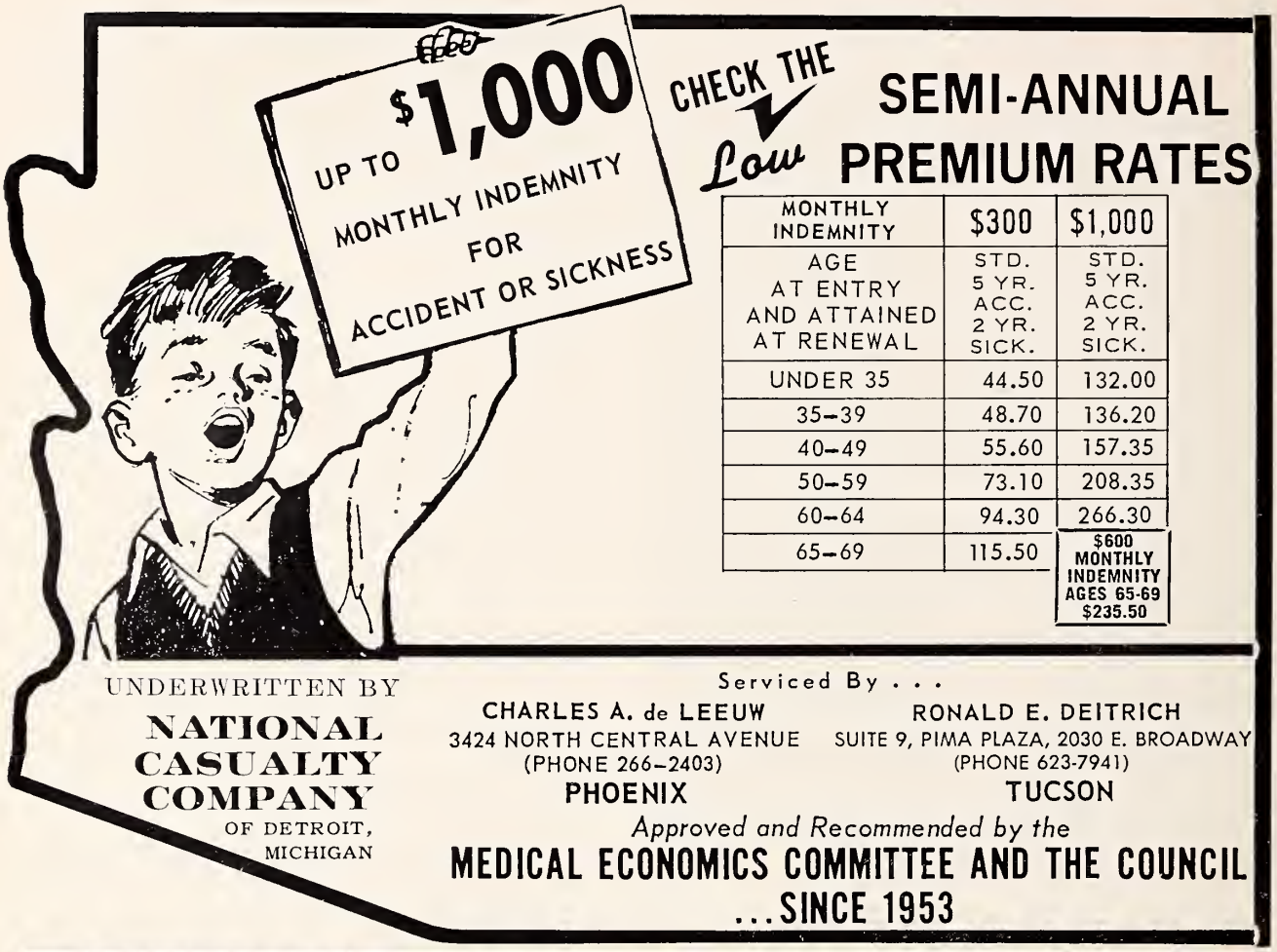
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-170



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35–39	48.70	136.20
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50–59	73.10	208.35
60–64	94.30	266.30
65–69	115.50	$600 MONTHLY INDEMNITY AGES 65-69 $235.50

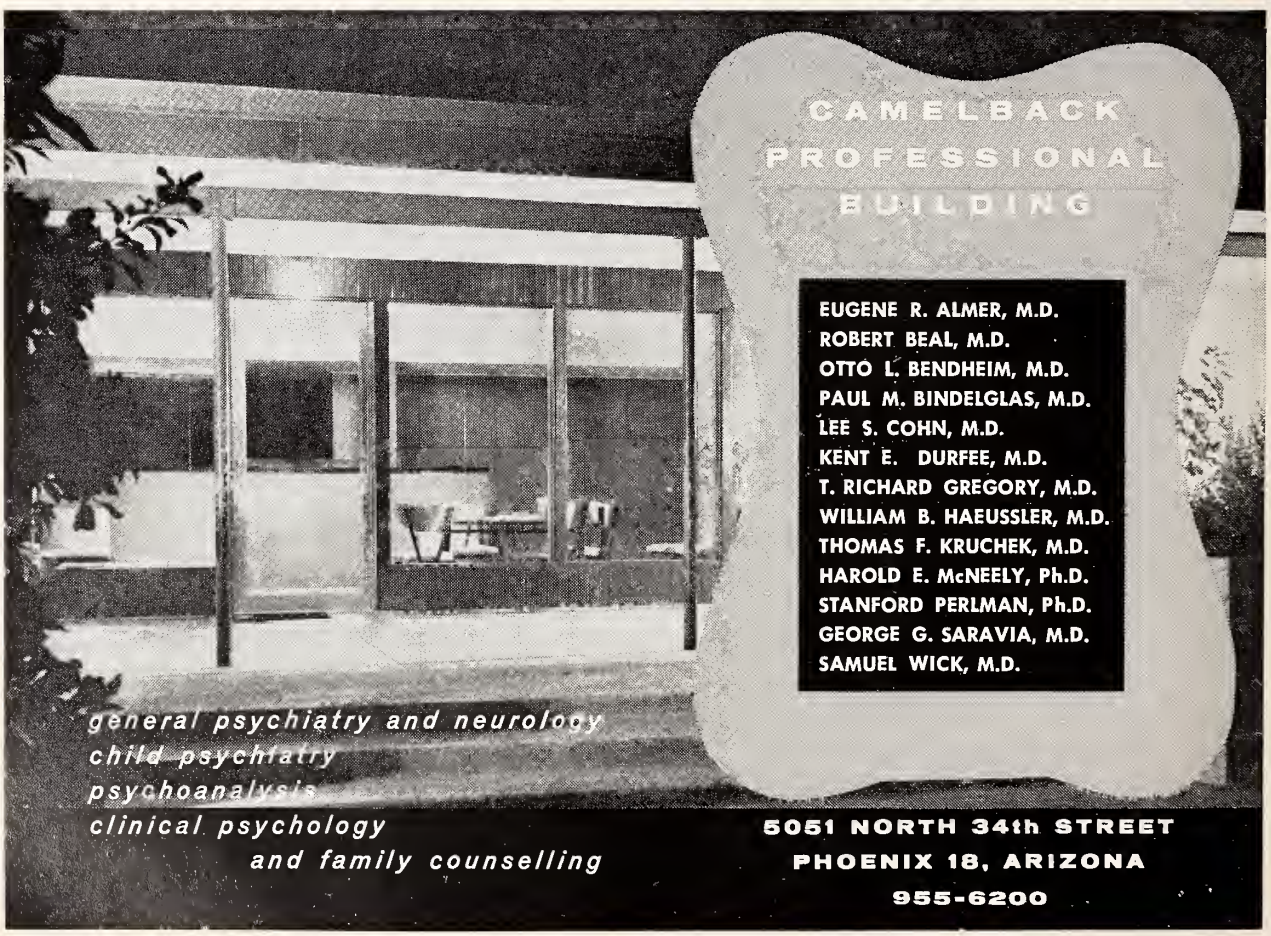
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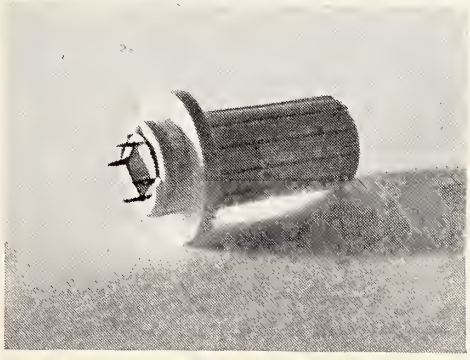
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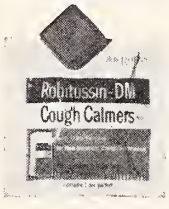
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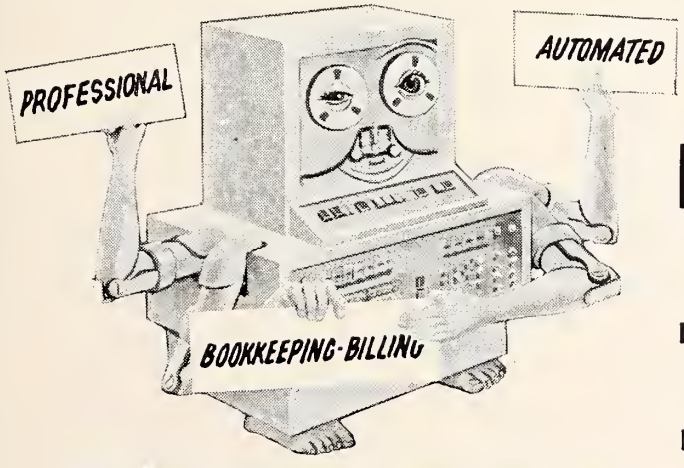
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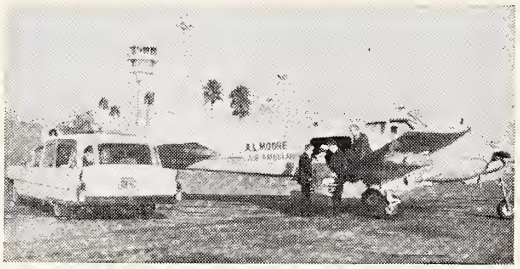
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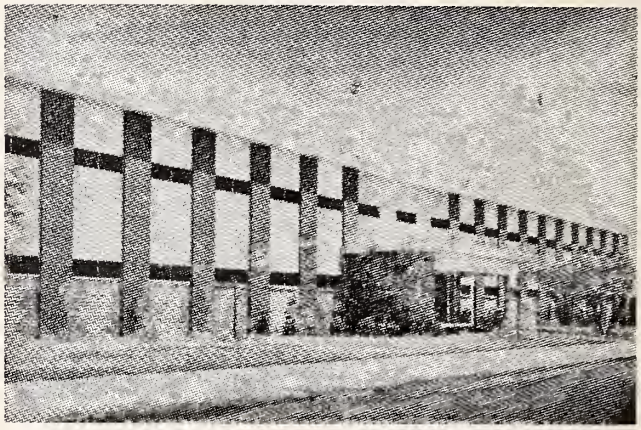
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Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils tachycardia; continuous observation is necessary.

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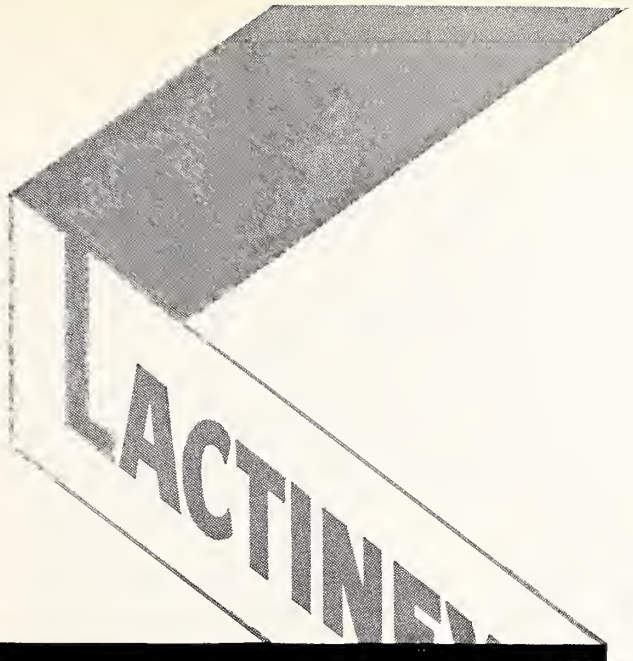
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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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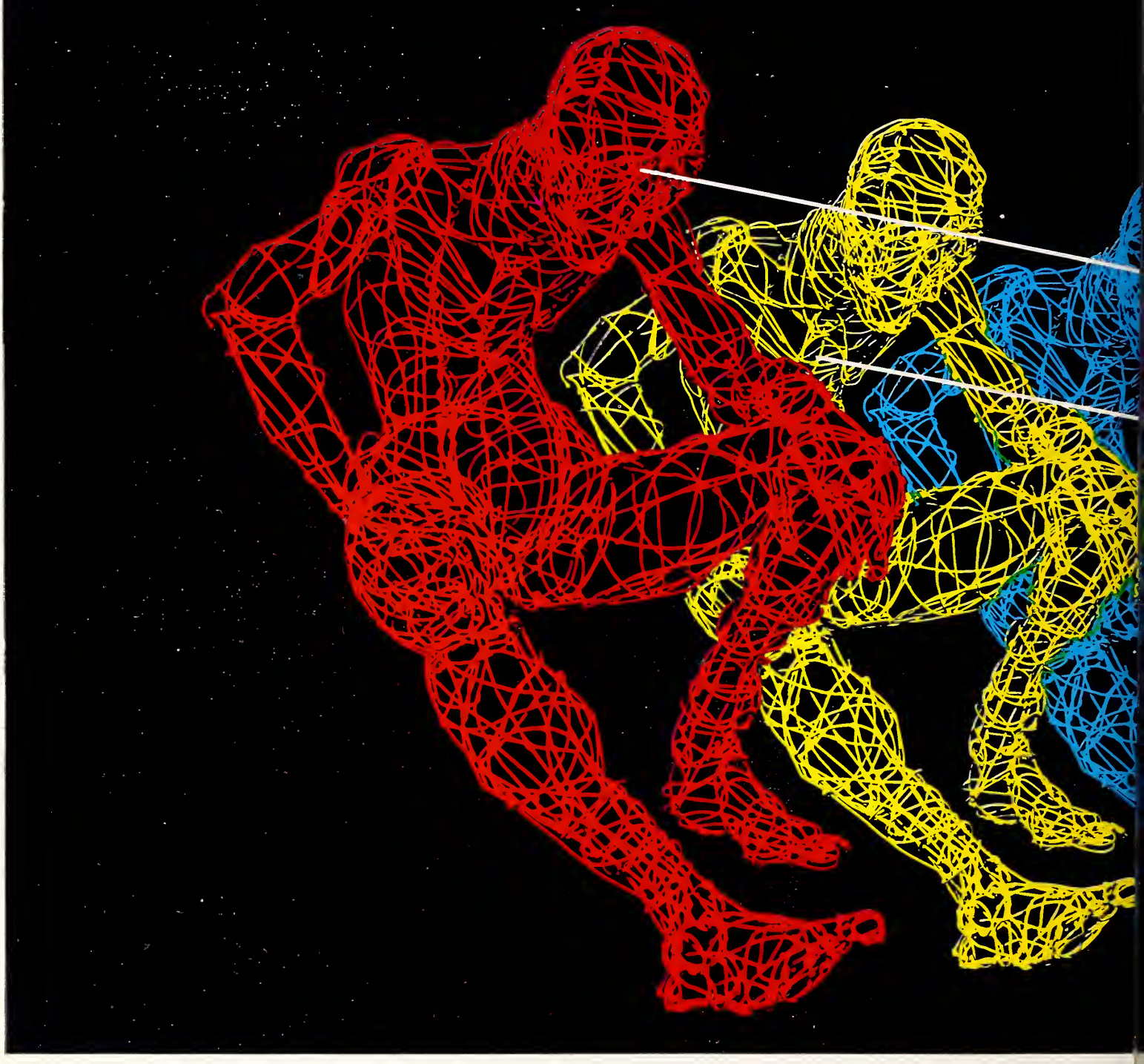
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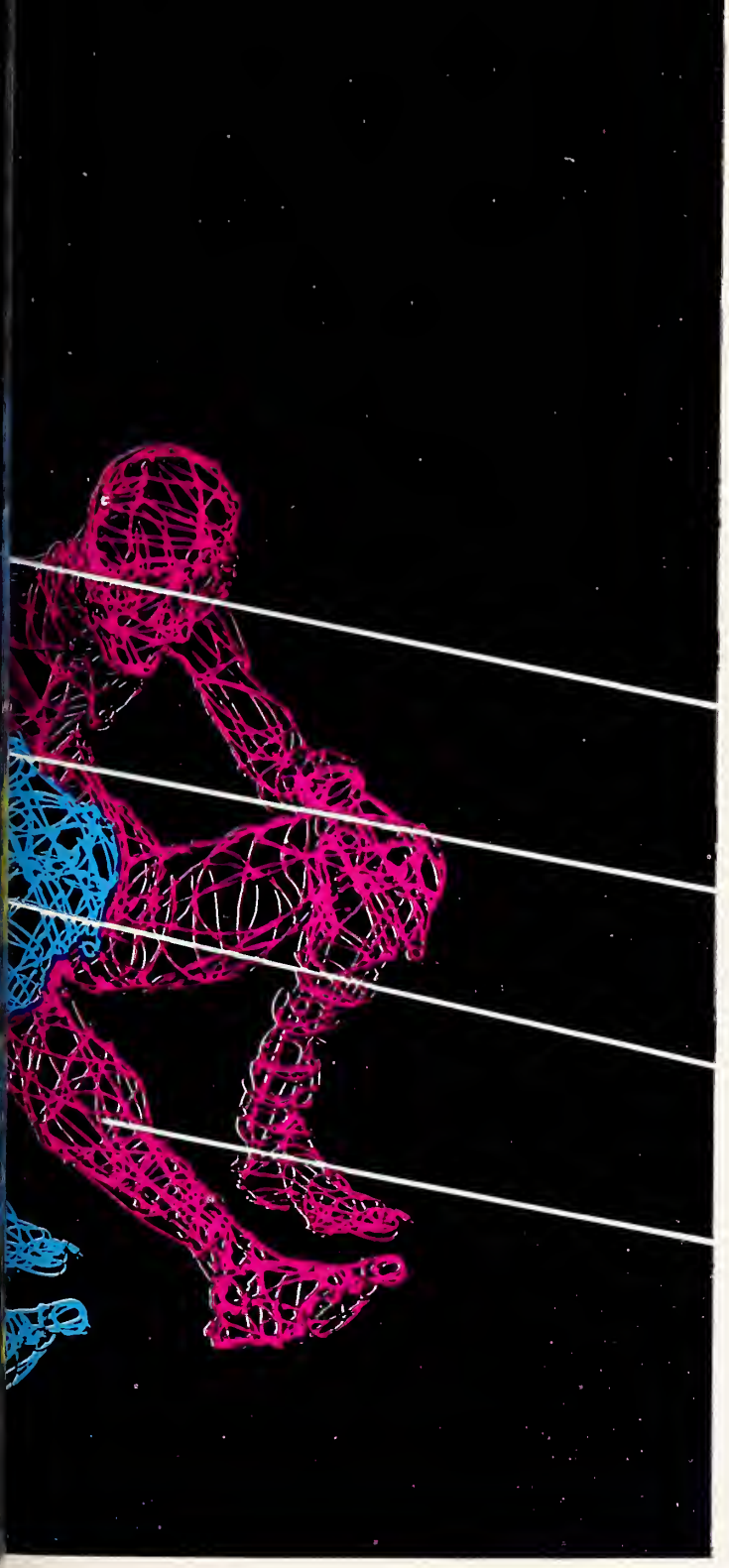
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Editor's Page

SEASON'S GREETINGS

This particular season should not need to be utilized for the following message, but your attention is nevertheless invited not only to the special assessment voted by our Board of Directors and our House of Representatives at the last Annual Meeting, but to the following excerpts from our Constitution and By-laws:

Chapter II, Section 4, (B), iv — "Active, associate or fifty-year membership in this Association shall be suspended by failure to pay the annual dues and assessments before the delinquency dates."

Chapter IX, Section 2: (in toto)

(a) Special assessments may be levied by the House at the Annual Meeting, or at any special meeting called for that purpose.

(b) Special assessments shall be payable thirty days after notice of such has been mailed, and shall be delinquent sixty days after such date. The Secretary of each county society shall collect and forward the special assessments to the Association Secretary.

(c) Any member who has not paid his special assessment by the delinquency date shall stand suspended until the assessment is paid.

The Special Assessment is in the amount of $125.00. It may be paid by two options; one, a single payment of $125.00, or ten annual payments of $15.00 each, and is payable to the Association directly.

The calendar for primary payments is:

Original statement with option — Sept. 25, 1968

Payment due (or exercise of option) — October 25, 1968

Delinquent notification — November 25, 1968

ARIZONA MEDICINE can in no way construe this as a season's greetings, so permit us all to wish all of you

MERRY CHRISTMAS
and
HAPPY NEW YEAR

Roland F. Schoen, M.D.
Editor



No one should be cold on a Caribbean cruise

To those with peripheral vascular disease, a balmy ocean breeze can become a limb-chilling wind . . . a stroll on the deck a painful, stop-and-go chore.

Priscoline can help. It dilates peripheral blood vessels, increases blood flow to extremities. Relieves numbness. Makes hands and feet less prone to chill. Makes patients more comfortable. Helps them get around.

Nothing magic about Priscoline. But people with peripheral vascular disease might think so.

See following page for prescribing information.

Priscoline®

(tolazoline)
peripheral vasodilator

CIBA

2/3851

Priscoline®
hydrochloride
(tolazoline hydrochloride)



Indications Spastic peripheral vascular disorders.

Precautions Tolazoline stimulates gastric activity and increases hydrochloric acid content of the stomach; use cautiously in patients with gastritis or peptic ulcer or in those with suspected peptic ulcer. Give cautiously, if at all, to patients with known or suspected coronary artery disease.

Adverse Reactions Occasional: nausea, epigastric discomfort, tachycardia, flushing, slight rise or fall in blood pressure, increased pilomotor activity with tingling or chilliness. Rare: vomiting, diarrhea. Symptoms are generally mild and frequently disappear with continued therapy, regardless of dosage.

Administration and Dosage Careful individualization of dosage is required.

Oral *Tablets:* Usually 25 mg 4 to 6 times daily is sufficient. If necessary, dosage may be increased gradually up to 50 mg 6 times daily.

Lantabs: Generally, 1 Lontab every 12 hours will achieve the same effect as one 25-mg regular tablet every 4 hours (6 times a day). Thus, continuous action throughout the night is achieved without the need for arising to take additional medication.

Parenteral *Subcutaneously, Intramuscularly, or Intravenously:* 10 to 50 mg 4 times daily. Start with low doses, increasing with patient under close observation until optimal dosage (as determined by appearance of flushing) is established. Keeping patient warm will often increase effectiveness of drug.

Supplied *Tablets,* 25 mg (white, scored); bottles of 100 and 1000. *Lantabs,* 80 mg (bright yellow); bottles of 100. *Multiple-dose Vials,* 10 ml, each ml containing 25 mg tolazoline hydrochloride, 0.65% sodium citrate, 0.65% tartaric acid, and 0.5% chlorobutanol as preservative in water; cartons of 1.

Lontabs® (long-acting tablets CIBA)

Consult complete literature before prescribing. 2/3851

CIBA Pharmaceutical Company, Summit, N.J. CIBA

Easy on the Budget...
Easy on the Mother
Tablets & Elixir
For Iron Deficiency Anemia

BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

FAMOUS Fergon®
brand of FERROUS GLUCONATE

See next page for prescribing information



You've made it one of your specifics in acute bronchitis

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specifics in acute bronchitis

Your experience has shown that H. influenzae and D. pneumoniae are commonly implicated in acute bronchitis. And DECLOMYCIN is effective against these organisms. Although some strains may resist its action, and other organisms may also be involved, sensitivity testing will prove the usefulness of DECLOMYCIN.

You know, too, that DECLOMYCIN provides rapid, high and prolonged activity levels in both serum and tissue.

Dosage is convenient—300 mg b.i.d. or 150 mg q.i.d.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—Anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg. q.i.d. or 300 mg. b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg.; **Tablets:** film coated, 300 mg., 150 mg. and 75 mg. of demethylchlortetracycline HCl. 393-8

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle



When she gets a bacterial infection, think of Tetrex-F.®

Like the debilitated or diabetic patient, she may be susceptible to monilial overgrowth.

That's why she needs the extra protection of Tetrex-F whenever tetracycline therapy is indicated. Tetrex-F provides well-tolerated tetracycline phosphate complex for the bacterial infection—nystatin to help prevent monilial overgrowth.

Tetrex-F®

(tetracycline phosphate complex-nystatin)

Whenever monilia may threaten tetracycline therapy

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A. H. F. S. Category 8:12**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201


Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in
ith Tandearil.

The trial period is brief: 1 week.
y one tablet q.i.d. at first. Tandearil
sually starts working within 3 to 4 days.
/hen response occurs, as little as 1 or
tablets daily may hold back pain and
iffness, and increase joint motion.

On the next page is a summary
f adverse reactions, contraindications,
arning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

ndearil, oxyphenbutazone:
r brief summary see next page.

Geigy

TA-6006



Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

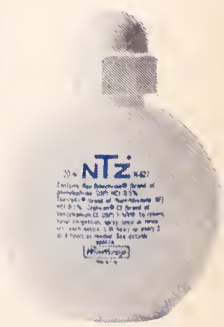
Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

the In peptic ulcer: antacid puzzle



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

Smiles speak louder than words

for the good taste of Soyalac

Milk-free, hypo-allergenic Soyalac has a pleasing taste that is eagerly accepted by most infants. It's similar to mother's milk in composition and assimilation, much like cow's milk in consistency and completely free of fibre. Extensive clinical data support Soyalac's value in promoting growth and development. Soyalac is also excellent for growing children and adults.



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Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.

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a product of

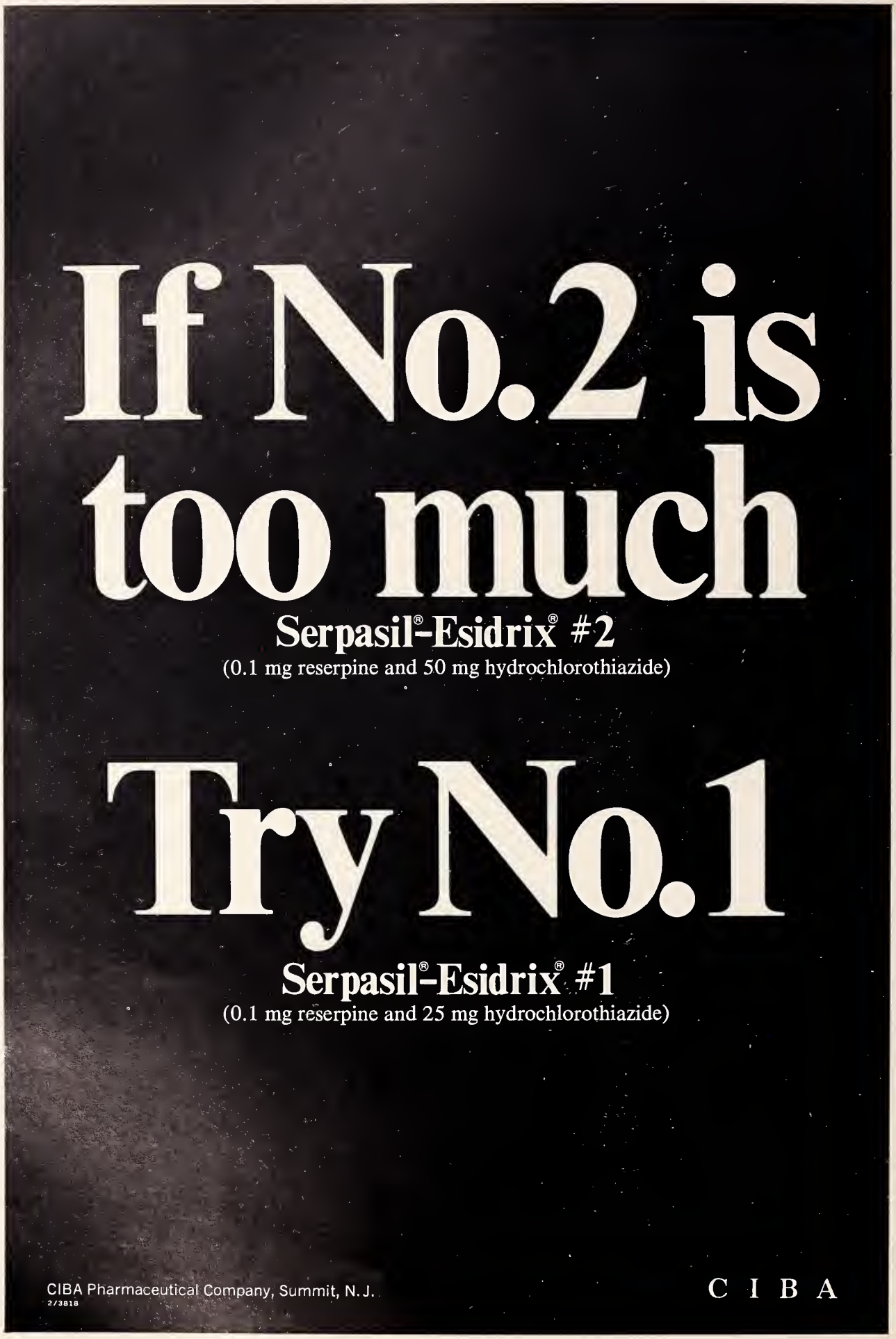
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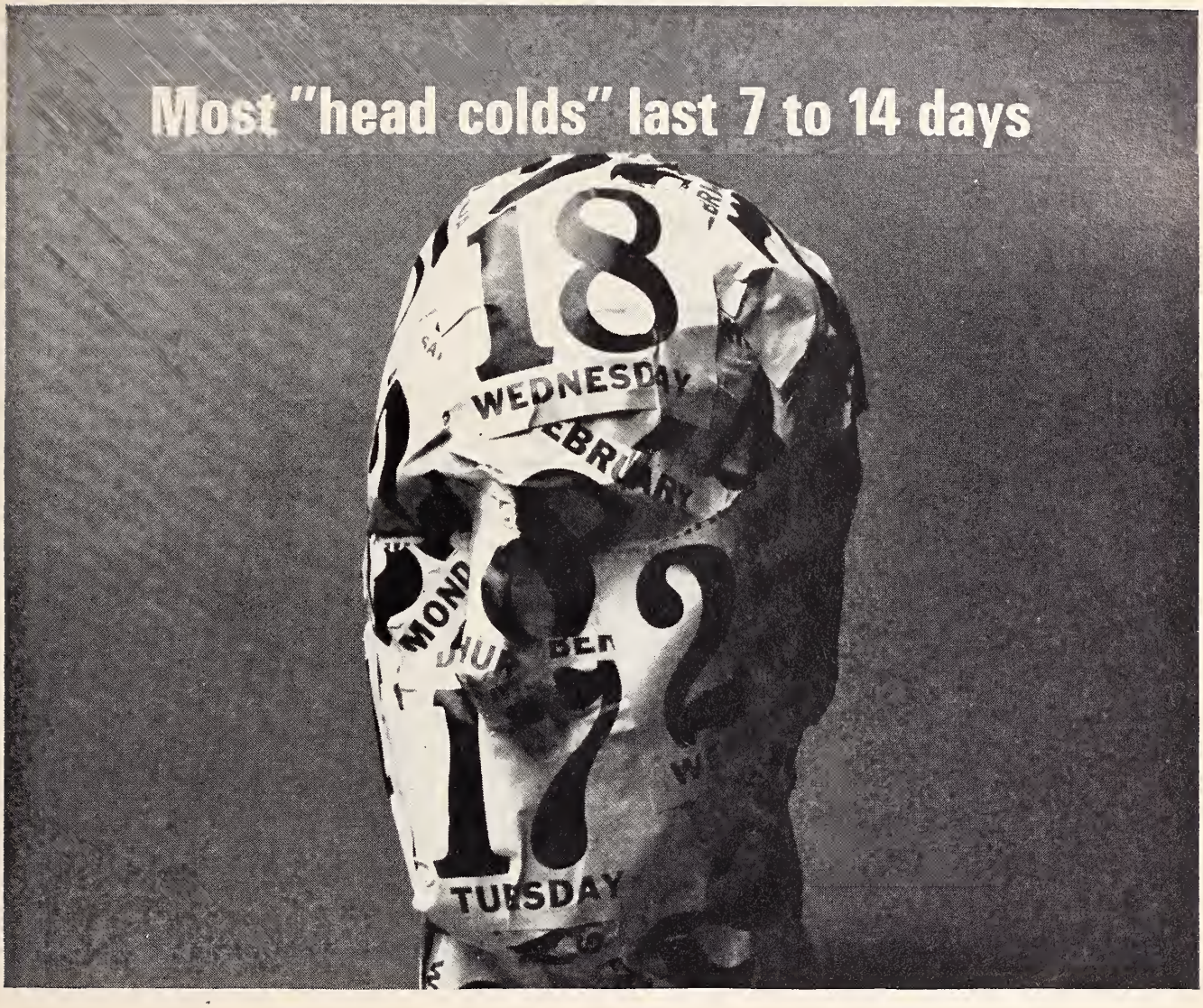
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RIVERSIDE, CALIFORNIA

Mount Vernon, Ohio, U.S.A.




If No.2 is too much
Serpasil®-Esidrix® #2
(0.1 mg reserpine and 50 mg hydrochlorothiazide)
Try No.1
Serpasil®-Esidrix® #1
(0.1 mg reserpine and 25 mg hydrochlorothiazide)
CIBA Pharmaceutical Company, Summit, N.J.
2/3818
CIBA



In the meantime...Ornade®

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

Ornade® Trademark Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.
Spansule® capsules brand of sustained release capsules

SK&F Smith Kline & French Laboratories

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PROFESSIONAL COMMITTEE: William G. Payne, M.D., Chairman (Tempe); Robert J. Antos, M.D. (Phoenix); Earl J. Baker, M.D. (Phoenix); Robert I. Cutts, M.D. (Tucson); Richard L. Dexter, M.D. (Tucson); Robert S. Ganelin, M.D. (Phoenix); William B. Helme, M.D. (Phoenix); Harold W. Kohl, Jr., M.D. (Tucson); W. Shaw McDaniel, M.D. (Phoenix); Dermont W. Melick, M.D. (Tucson); Hermann S. Rhu, Jr., M.D. (Tucson); Donald F. Shaller, M.D., (Phoenix); Albert G. Wagner, M.D. (Phoenix); MacDonald Wood, M.D. (Phoenix).

MEMBERS ARE URGED TO BRING MATTERS OF INTEREST AND CONCERN TO THE CHAIRMEN OF THE APPROPRIATE COMMITTEE OR TO THE ATTENTION OF ANY MEMBER OF THE BOARD OF DIRECTORS.

AN INVOLVED MEMBERSHIP IS THE BASIS FOR AN EFFECTIVE ASSOCIATION.

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MARICOPA: Arthur R. Nelson, M.D., President, 926 E. McDowell Rd., Phoenix; Donald F. Schaller, M.D., Secretary, 55 W. Catlina Drive, Phoenix.
(Society Address: 2025 North Central Avenue, Phoenix)

MOHAVE: George M. Clarke, M.D., President, 412 East Oak Street, Kingman; John J. Standifer, M.D., Secretary, 412 East Oak Street, Kingman.

NAVAJO: Leo L. Lewis, M.D., President, P. O. Box AT, Winslow; George G. Bertino, Jr., M.D., Secretary, 1500 Williamson Avenue, Winslow.

PIMA: John A. Wilson, M.D., President, 1601 N. Tucson Boulevard, Tucson; Seymour I. Shapiro, M.D., Secretary, Bldg. 24, Med. Square, 1601 N. Tucson Blvd., Tucson.
(Society Address: 2555 East Adams Street, Tucson)

PINAL: William J. Clemans III, M.D., President, 1616 Main Street, Florence; Robert L. Hyde, M.D., Secretary, 1616 Main Street, Florence.

SANTA CRUZ: Stephen A. Letourneaux, M.D., President, 711 Morley Ave., Nogales; Charles S. Smith, M.D., Secretary, Gebler Building, Nogales.

YAVAPAI: Edward L. Ritter, M.D., President, 533 West Gurley Street, Prescott; William R. Shepard, M.D., Secretary, 1003 Division Street, Prescott.

YUMA: John F. Stanley, M.D., President, 201 First Avenue, Yuma; Dale F. Webb, M.D., Secretary, Avenue A and 24th Street, Yuma.

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301 Cole Avenue, Warren 85642

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700 East 10th St., Casa Grande 85222

COMMUNITY HEALTH: Mrs. Harry D. Bryan
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CONVENTION Mrs. Howard Kimball (Ella)
414 W. Northview Avenue, Phoenix 85021

FINANCE: Mrs. James L. Parsons
5251 E. Hawthorne, Tucson 85711

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1677 E. Maryland, Phoenix 85016

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5250 Bartlett Circle, Phoenix 85016

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1001 Norris Road, Prescott 85018

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6130 N. 52nd Place (945-9250), Paradise Valley 85251

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1226 E. Cambridge Ave. (265-2507), Phoenix 85016

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1513 E. San Miguel, Phoenix 85014

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301 Cole Ave. Warren 85642

PARLIAMENTARIAN: Mrs. Clare W. Johnson (Mary Anne)
318 W. Lawrence Rd. (266-1410), Phoenix 85013

PUBLICATION: Mrs. Hubert R. Estes (Mickie)
9035 E. Woodland Road (298-1289), Tucson 85715

SAFETY-DISASTER PREPAREDNESS:
Mrs. Charles I. Fisher (Peggy)
352 W Berridge Lane, Phoenix 85013

WA-SAMA Mrs. Bryant I. Pickering (Jean)
4801 E. Sparkling Lane, Paradise Valley 85251

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MARICOPA Mrs. George L. Hoffmann (Julie)
900 W. Mountain View Dr., Mesa 85201

COCONINO Mrs. Darius Benham (Esther)
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YUMA Mrs. Paul Slosser (Betty)
701 E. 8th Avenue, Yuma 85364

PIMA Mrs. Richard F. Dahlen
3210 E. Via Palos Verdes, Tucson 85716

YAVAPAI Mrs. John Oakley (Helen)
405 Delano, Prescott 86301

GILA Mrs. Thomas Jarvis (Barbara)
1266 Skyline Drive, Globe 85501

ArMA Reports

AD HOC BUILDING COMMITTEE

Meeting of the Ad Hoc Building Committee of The Arizona Medical Association, Inc., held Saturday, October 5, 1968, in the Central Office at 4601 North Scottsdale Road, Scottsdale, Arizona, convened at 1:20 p.m., Robert A. Price, M.D., Chairman, presiding.

ROLL CALL

PRESENT: Drs. Dudley, Jr., Arthur V., President; Heileman, John P., Secretary; Price, Robert A., Chairman; Young, Woodson C.

STAFF: Mr. Robinson, Bruce E., Assistant Executive Secretary.

EXCUSED: Drs. Dew, Philip E., Treasurer; Dysterheft, Arnold H., Past President; Flynn, Richard O., President Elect; Landeen, Fred H., Vice President; Nelson, Arthur R.

MINUTES

It was regularly moved and unanimously carried that the minutes of the meeting held September 12, 1968 be approved as distributed.

ARCHITECT SELECTION

Representatives of the following architectural firms made detailed presentations concerning the background of their respective firms and the projects in which they have been involved.

1:00 p.m. — Varney, Sexton, Sydnor Associates
2:00 p.m. — Doyle Flynn & Associates
3:00 p.m. — Donald B. Schwenn, Architects
4:00 p.m. — Guirey, Srnka & Arnold
5:00 p.m. — Bennie M. Gonzales Associates

Following the five presentations the committee discussed in depth the attributes of each firm. It was agreed that any one of the five would do an excellent job for the Association.

Following several hours of deliberation it was reguarly moved and unanimously carried that the firm of Bennie M. Gonzales Associates be retained as the architect for our headquarters building project.

ARMADA ASSURANCE AGENCY

The committee was advised of the request of the ARMADA ASSURANCE AGENCY for space in the building. It was determined to refer the matter to the Executive Committee for action.

MEETING ADJOURNED 7:20 P.M.

John P. Heileman, M.D.
Secretary

GOVERNMENTAL SERVICES COMMITTEE

Meeting of the Governmental Services Committee of The Arizona Medical Association, Inc., held Sunday, October 6, 1968 in Suite 201, 4601 North Scottsdale Road, Scottsdale, Arizona, convened at 10:40 a.m., William B. Steen, M.D., Chairman, presiding.

ROLL CALL

PRESENT: Drs. Caldwell, Hayes W.; Dries, Charles P.; Farnsworth, Stanford F.; Flynn, Richard O., President-Elect; Heileman, John P., Secretary; Melick, Dermont W.; Scott, Woodrow W.; Stannard, Dale H.; Steen, William B., Chairman.

STAFF: Mr. Robinson, Bruce, Assistant Executive Secretary.

GUESTS: Messrs. Beckwith, Tim, Superintendent, Aetna Life & Casualty Co.; Blazek, James J., Administrator, Aetna Life & Casualty Co.; Yost, Donald, Governmental Services Coordinator, Arizona Blue Cross-Blue Shield.

EXCUSED: Drs. Alexander, Clifton J.; Bishop, Jr., William A.; Dudley, Jr., Arthur V., President; Letourneaux, Stephen A.; McDonald, Richard T.; Ochsner II, Albert J.; Reed, Wallace A.; Spendlove, George A.; Treptow, Keith R.; Walker, Glen H.; Mr. Carpenter, Robert.

MINUTES

Minutes of the meeting held July 21, 1968, approved as distributed.

INTRODUCTIONS

Woodrow W. Scott, M.D., newly appointed to the committee, was introduced.

INTERMEDIARY — PART A — ARIZONA BLUE CROSS

Mr. Donald E. Yost, Governmental Services Coordinator, Arizona Blue Cross reported that there has been a major change in the methodology of handling ECF claims by the intermediaries. He pointed out that the providers of service are required to submit with every admission:

1. Copy of doctor's orders
2. Copy of the transfer information form
3. Summary sheet designed by SSA

After the ECF demonstrates their ability to distinguish the difference between covered and not-covered services, then they will not be required to submit all of this documentation on every case. They would submit this material only on cases where coverage is questionable. They are also required to have their utilization committee review the questionable case within seven days. They are to render an opinion as to whether they think the case is coverable or not coverable. In the final analysis, the intermediary has the sole responsibility of determining the coverage even though its opinion differs from that of the provider and/or its utilization committee. HEW has defined extended care as follows:

> "As the level of care when the patient's condition upon discharge from a hospital requires him to be in an institution for the 'primary' purpose of receiving continuous skilled nursing services and other professional services.
>
> "Skilled services must be furnished by or under supervision of trained medical or paramedical

personnel. Any level of care less intensive than extended care is 'noncovered care.' Formerly, all noncovered care was termed 'custodial care.'"

Mr. Yost also announced Dr. George L. Cannon as medieal advisor on Medicare and ECF matters.

Mr. Yost discussed the new "Continuing Care Transfer Information" form which they would like to see used in all ECF transfers. It was regularly moved and unanimously carried that this form be approved.

CARRIER — PART B — AETNA LIFE & CASUALTY

Dr. Heileman reported on the Board of Directors' aetion of 9/8/68 regarding consolidating present medical review committees into the Governmental Services Committee.

The matter of establishing a Seetion on Medical Review was discussed. Letters from Drs. Patrick P. Moraca, Dale F. Webb, and Alexander J. Bosse regarding these matters were received and reviewed. It was pointed out that members of the Seetion on Medical Review would visit Dr. Bosse to discuss his problem in more detail.

It was regularly moved and unanimously carried that a Section on Medical Review be created; the Section to be composed of the following:

Woodrow W. Scott, M.D., Chairman
Clifton J. Alexander, M.D.
Hayes W. Caldwell, M.D.
Richard T. McDonald, M.D.
Patrick P. Moraea, M.D.
Wallace A. Reed, M.D.

A brief review of the actions of the Review Committee in meeting held earlier this day was made. It was pointed out that so far, only nine physicians in the entire state have had cases come before the Review Committee. It was noted that this is less than ½% of the membership whieh is exceedingly low for such a large program.

SECTION ON COMPREHENSIVE HEALTH PLANNING

Dr. Farnsworth requested guidance on the future function of this section. He pointed out that the State Health Planning Authority has been formulated and that Maricopa County has an operating agency and Pima County has one in a planning stage.

The eommittee recommended that this section continue to funetion in an advisory capacity.

SECTION ON ECONOMIC ASPECTS OF MEDICARE PHYSICIANS' OFFICE RECORDS

Dr. Caldwell reported on his investigation of the question of whether or not the Part B Carrier had the right to enter a doctor's office and go through his records. He noted that John A. Rowland, Acting Director, Department of Health Care Financing of AMA, has advised that the Carrier does **not** have such a right.

CENTRAL DATA BANK

Dr. Caldwell gave background information on the concept of a Central Data Bank of patient laboratory information. He noted that a meeting with James Goddard, M.D., former head of FDA, was held on this general subject. The question of patient consent was noted. At this point, the matter of costs seems to be the road bloek.

SECTION ON REGIONAL MEDICAL PROGRAMS

Dr. Melick reported on his visitation to the Albany Regional Medical Program which has a very extensive program. He also reported on the Conference of Coordinators held in Washington, D.C., September 30-October 1. A condensation of the program was taken from the report of Stanley W. Olson, M.D., the new national Director of the programs, as follows:

"**Medical Centers and Medical Schools** — These have provided much of the **initial** Program impetus. A close relationship between them and the Program **must continue** because medical centers constitute a reservoir of professional expertise and competence that must be drawn upon for the transmission of new knowledge and techniques. They have considerable potential for serving as a "change agent" and they are a highly specialized resource for obtaining quality health care. This is not to say that medical schools can or should control the Program. To the contrary, continued exercise of control by this or by **any** single institution or group will impede and retard the involvement and commitment of **other** key groups. But without medical center involvement and commitment, there is little chance that the Regional Medical Program can succeed.

"Another important group includes **practicing physicians** — and by extension, State medical societies and their component organizations. It is essential that practitioners be involved in Regional Medical Programs. Not only are they the first point of contact with the health eare system, but many significant improvements in the quality of eare and in the health status of a population can be achieved only through their direct efforts. But simply 'involving' **individual physicians** is not enough. Organized medicine — State medical societies and their component organizations — must participate in the Regional Medical Program decision-making process. In terms of the health power structure, organized medicine represents the colleetive voiee of physicians. We have seen instances where failure to involve these groups in decision-making has created obstacles to program advancement.

"A third and equally important group includes **hospitals.** They represent the major institutional focus for health eare in this country. Diagnosis and treatment are increasingly hospital-oriented and hospital-based. Moreover, the hospital represents an important interface with the community which surrounds it and represents both the providers and consumers of health eare. The involvement and commitment of the hospitals, therefore, must be broadly structured to include the administration, medical staff, and trustees.

"Fourth, **Official and Voluntary Health Agencies** — It may be easy to overlook these groups or to wait for them to ask for participation and then to expect from them only a nominal contribution. Such a policy is shortsighted and self-defeating.

> **State and local public health agencies** play a a signifieant role in the provision of health care. No Region can afford to ignore or proceed without the understanding and backing of city and state health officers, many of whom have the ear of a Governor or a Mayor. Moreover,

the statewide and areawide comprehensive health planning agencies, which will play an increasingly important complementary role in structuring the health care system, are by law related to state and local governments — often through their health departments.

"We are pleased to note that many sponsoring organizations clearly recognize that the Regional Advisory Group must become the dominant organization expressing policy on behalf of all cooperating health interests in the Region. It clearly takes time for a Regional Advisory Group to become organizationally mature, to come to grips with important policy problems, and to begin resolving them wisely. They determine the overall scope, nature and direction of the Regional Medical Program and establish priorities. Thus, Regional Medical Programs emerges on the American health scene as a voluntary mechanism that depends upon the organizational behavior of health-related institutions — a 'coalition politics' of health, if you will.

"Clearly, we are moving from a circumstance in which there has been a surplus of funds (at times an embarrassing surplus) to one in which the reverse will be the case. Based on applications in hand, we can predict that the aggregate demand for grant funds will exceed our appropriations in the fiscal years 1969 and 1970; and beyond that, the amounts which the Review Committee and the National Advisory Council will likely recommend for approval will also exceed the available funds.

"This matter was discussed in depth by the National Advisory Council at its meeting in August of this year. The Council has indicated it will continue to judge programs and operational grant applications on the basis of quality. They have rejected the principle of a distributive mode for the allocation of funds based on population or geography. Inevitably, this policy will lead to a backlog of approved but unfunded applications. As we enter a period in which funds exceed requests, Regions will be judged competitively.

"The first issue relates to the matter of how Regional Medical Programs may serve an effective function in improving the care received by the large population groups in our cities and especially that received by the poor and disadvantaged groups living in the ghettos. The complex problems our cities present, pose a national crisis of the gravest order. The health of the poor who live in the cities is of deep concern to Regional Medical Programs. True, we suffer from several constraints as we attempt to deal with this problem. Facilities are needed, but we have no authority to use funds for construction of facilities. Neither may grant funds be used to pay for the cost of medical services or the cost of hospitalization. Nevertheless, there are major contributions which Regional Medical Programs can make but which can be made only if we understand the nature and mechanisms to be employed in Regional Medical Programs, and understand also the nature of the problems faced by our cities in improving health care for the poor. The problem with us today is that many of the poor have neither an adequate indigent type of service nor funds to purchase their own care.

"Regional Medical Programs can assist in the improvement of health service activities through projects that supplement and catalyze elements of both old and new systems aimed specifically at the urban poor. To do this, Regional Medical Programs must enter into cooperative arrangements with the many local and Federal programs already addressing themselves to health problems of the urban poor. But regions must first be able to function as Regional Medical Programs.

"The second issue is that of continuing education. From the beginning there has been some degree of controversy about the role and significance of continuing education in Regional Medical Programs. There were some who saw continuing education as the whole program. Others saw very little purpose to be served by supporting the kinds of ineffective continuing education programs which rely mainly on information transfer, which reach relatively small numbers of physicians and which appear not to change the behavior of physicians to any significant degree.

"I am convinced that continuing education is the most significant single component of Regional Medical Program activity. What is at issue is not whether we should support and extend continuing education but what kind of continuing education we should encourage.

"Having identified these two issues which would seem to be polarized, as are so many national issues today, on the needs of the cities versus the needs of the rural areas, I should like to reject firmly the notion that we are unaware of the health needs of the rural poor or the importance of including them as beneficiaries of a system of voluntary functional regionalization. Equally, I would like to reject the notion that physicians in the urban areas are not in need of continuing education simply because of their proximity to the centers of learning. In our larger cities many physicians practice independently, without hospital appointments, and are subject to none of the influences which are of major benefit to all physicians who do conduct a substantial part of their practice in an organized hospital setting. We can ignore neither these physicians nor the patients they serve.

"The true significance of the Regional Medical Program effort can be understood only if we recognize that a test is being made, nationwide to determine whether the quality of health services can be continuously improved by means of voluntary, functional regionalization. We are engaged in resolving an issue of critical significance to the future of the American health care system — a system which in the aggregate involves the life and welfare of 200 million persons — a system in which more than $50 Billion is invested annually. The best estimates we have of the cost of a fully established regionalization program suggests that we may require $400 to $500 Million annually.

"Ours is a program that has its primary impact on the providers of care rather than on the public directly. We depend, therefore, on those professionally involved in health care to interpret the success of efforts. They in turn must communicate their understandings of the value of the Program to the Public and to the Public's representatives in the Congress."

ARIZONA REPORT

Dr. Melick reported that two operational grant applications have been submitted to date. One is a chronic

respiratory disease program which we believe will be funded. The program is in the amount of $219,000.00.

The second program is to establish an Arizona medieal library network. This would connect the following libraries by Kelly Typewriter Exchange Network:

Maricopa County Medical Society
Northern Arizona University
Cochise College
Arizona Western
St. Joseph's Hospital, Phoenix
VA Hospital — Phoenix
VA Hospital — Tucson
VA Hospital — Prescott
College of Medicine, University of Arizona

This project is expected to be funded at $144,000.00.

FUTURE

Activities are developing in coronary care units, stroke rehabilitation units, and three or four other projects.

It was pointed out that as the programs are expanded, greater areas of the State will become involved.

SECTION ON TITLE XIX

Pima Project

Dr. Heileman reported the action of the Board of Directors regarding turning down the committee's suggestion relative to publicizing the Welfare Board's action in killing the project.

The Indians and Title XIX

Letters from Morris K. Udall and Paul Fannin regarding the inclusion or exclusion of the Indians in Title XIX were read. It was noted that a meeting has been called by Representative Udall in Washington, D.C., on Monday, October 7, 1968 to discuss the ramifications of this problem.

SECTION ON UTILIZATION REVIEW

Dr. Bishop not being present, his report was read by Dr. Heileman as follows:

"In accordance with the recommendations of the entire committee at the last meeting, we formulated a questionnaire which was sent out with the aid of Bruce Robinson.

Enclosed is a summary of the replies plus additional replies which came in late and which I am sending for your consideration. Notice that we mailed questionnaires both to the chief of staff and chief of the Utilization Review Committee.

After reviewing these, it was my opinion that any meeting at this time would not be helpful. I talked to Bruce who attended all three of the other meetings and he was of the same opinion.

I would like your opinion. If you feel differently, we will try to get in gear; otherwise, will see you at the next regular meeting.

Please hang on to these questionnaires so that they may be filed after they have served their purpose at our next meeting."

COMMUNICATIONS

Visiting Nurse Fees

Dr. Meredith's letter dated August 3, 1968 regarding the difference between VNS house call fees and M.D. house call fees was discussed. It was determined that communication be started with the VNS to determine in more detail, the basis for their charges so that this matter can be clarified.

Consulting Services Corporation

A letter dated July 30, 1968, from the entitled firm advising that they are going to audit certain O.E.O. programs in Arizona was read and received.

OTHER BUSINESS

Section Assignments

The following new members were assigned to the sections indicated:

Stephen A. Letourneaux, M.D. — Section on Regional Medical Programs
Richard T. McDonald, M.D. — Section on Economic Aspects of Medicare
Dale H. Stannard, M.D. — Section on Title XIX
Glen H. Walker, M.D. — Section on O.E.O. Programs

MEETING ADJOURNED AT 12:45 P.M.

John P. Heileman, M.D.
Secretary

SCIENTIFIC ASSEMBLY COMMITTEE

Meeting of the Scientific Assembly Committee of The Arizona Medical Association, Inc., held in the Central Office of the Association, Suite 201, 4601 North Scottsdale Road, Scottsdale, Arizona, Saturday, October 12, 1968, convened at 1:10 p.m., Edward Sattenspiel, M.D., Chairman, presiding.

ROLL CALL

PRESENT: Drs. Bishop, William E.; Flynn, Richard O., President-Elect; Gregory, T. Richard; Grossman, Raymond; Levy, Philip; Middleton, William F.; Phillips, Melvin W.; Potter, Wilfred M.; Sattenspiel, Edward, Chairman; Saylor, Blair W.; Zeluff, Reginald J. M.

STAFF: Messrs. Boykin, Paul R., Executive Secretary, BOMEX; Carpenter, Robert, Executive Secretary, ArMA; Robinson, Bruce E., Assistant Executive Secretary, ArMA.

GUEST: Dr. Wertz, Max L., Chairman, Golf Tournament.

EXCUSED: Drs. Alexander, Clifton J.; Bright, Daniel; Currin, John F.; Dudley, Jr., Arthur V., President; Dworin, Milton; Heileman, John P., Secretary; Jackson, Rockwell E.; Kent, Jr., George B.; Landeen, Fred H., Vice President; Linkner, Laurance M.; Nelson, Arthur R.; Welsh, John S.

MINUTES

Minutes of the meeting held July 6, 1968, were approved as distributed.

BOARD OF DIRECTORS' ACTIONS

It was reported that the recommendations emanating from the July 6, 1968 meeting, and referred to the Board of Directors, were approved by the Board with one addition. This was the addition of a registration classification: "Package Deal for one member — $25.00" to include one ticket to the steak fry and one ticket to the President's Banquet.

SCIENTIFIC PROGRAM

Discussion was had on the subject of presenting each guest speaker with a gift that would be symbolic of the Southwest. Such gifts to be presented at the President's Banquet on Friday, April 25, 1969.

Tulane University School of Medicine

Dr. Sattenspiel reported on his visit with John J. Walsh, M.D., Dean, Tulane University School of Medicine, on October 8, 1968. Following extensive discussion on subjects, panels, etc., Dr. Sattenspiel was directed to contact Dr. Walsh and advise him of the following recommendations.

PANELS

Breakfast:

1. "The Effect of Family Planning on Maternal and Child Health." (Should include OB-GYN man and a Pediatrician)
2. "Medicare: Impact on practicing physician; effect on post-graduate medical education." (Should include Erwin Witkin, M.D.)

Afternoon:

1. "Emphysema and Chronic Obstructive Pulmonary Disease." (Should include an Internist, Radiologist and Surgeon. Dr. Adriani was recommended as a possible speaker.)
2. "Acute Neck and Back Trauma: Organic vs. Functional Symptoms." (Should include Orthopedist, Neurosurgeon and an OTO man.)

INDIVIDUAL PAPERS

Specialty	Suggested subjects
Internal Medicine	Pulmonary diseases
(2). (Suggest one	Allergy
to be Dr. Burch)	G.I. diagnosis
General Surgery	Cardiology
OB-GYN	Organ transplants
Pediatrics	Diseases of vulva
Orthopedics	Abnormal sexual development
	— optional —
Radiology	Pediatric allergies
Neurology	Traumatic hand and foot
(Suggest Dr.	injuries
Heath)	Angiography
Anesthesiology	Biochemistry of schizophrenia
(Suggest Dr.	Pharmaceutical-Pathological
Adriani)	effects of drugs on surgical
OTO	anesthesia
Urology	Chronic ear disease
(Suggest Dr.	G-U cancer
Schlegel)	(Speaker's choice)
Dermatology	

Dr. Walsh is to be requested to submit a list of 12 or 13 speakers along with a list of at least three topics upon which each would be willing to speak. Dr. Walsh is to be asked to submit this information as soon as possible so that administrative details can be started.

PUBLICITY

The proposal submitted by Mr. John S. Turner, dated October 10, 1968, was read and discussed in depth.

It was regularly moved and unanimously carried that Mr. Turner's proposal be accepted with the understanding that Mr. Carpenter will work closely with Mr. Turner so that past problems could be avoided. The Public Relations Committee is to be contacted and asked to assist in this activity.

1970 SCIENTIFIC PROGRAM

The need for planning the 1970 scientific program was emphasized by Dr. Sattenspiel. Dr. T. Richard Gregory, Chairman of the 1970 meeting, was directed to make contact with the medical schools as soon as possible. The following medical schools were recommended by the committee.

1. University of Texas Southwestern Medical School (Dallas)
2. University of Illinois College of Medicine (Chicago)
3. University of Oregon Medical School (Portland)
4. University of Washington School of Medicine (Seattle)

PROMOTION OF ATTENDANCE

ArMA Members

Mr. Robinson reviewed the methods used to promote attendance of ArMA members at the 1968 meeting. He recommended that a similar program be used for the 1969 meeting. The committee was in agreement with this recommendation.

Out-of-State M.D.s

A presentation was made on promoting attendance from M.D.s living in Colorado, Nevada, New Mexico, Montana, Utah and Wyoming. Mr. Robinson stated that it would cost approximately $1,030.00 to conduct a one-time direct mailing to the 5,388 physicians in these states. The committee decided not to use the direct mail route this year, but suggested that we attempt to have announcements of the meeting published in the journals going to the M.D.s in the above mentioned states.

Arizona Osteopaths

Discussion was had on the method of carrying out Resolution No. 1 adopted by the House of Delegates on April 27, 1968.

The committee recommends to the Board of Directors that invitations be directed to the individual osteopaths in Arizona during the first half of March 1969. Said invitations are to include the complete program as well as pre-registration forms.

SCIENTIFIC PAPERS AND EXHIBITS

Dr. Sattenspiel, Dr. Gregory, Dr. Levy and Dr. Middleton were appointed to review scientific papers and scientific exhibit applications submitted for consideration for presentation during the 1969 annual meeting.

TENNIS TOURNAMENT

It was noted that Everett W. Czerny, M.D. (Tucson) has accepted the chairmanship for the tennis tournament. Dr. Sattenspiel was directed to contact Dr. Czerny regarding the specifics of the tournament.

GOLF TOURNAMENT

Dr. Wertz reviewed his plans for the golf tournament. It was decided that the tennis and golf tournaments will be handled as independent activities, especially with regard to obtaining trophies.

PRESIDENT'S BANQUET

General discussion ensued relative to the program for the President's Banquet. It was generally agreed that there would not be a guest speaker unless an outstanding individual becomes available at a later date.

It was suggested that the guest speakers be seated at a second head table. The idea of giving table gifts to those attending was discussed, but no decision was made.

ArMPAC ANNUAL DINNER

Dr. Kahle's report was read as follows:

"Would you please convey to the Scientific Assembly Committee the fact that ArMPAC is planning a banquet for the Thursday evening, April 24, 1969. The ArMPAC Banquet Committee will be comprised of Mrs. Robert J. Oliver, President-Elect of the Woman's Auxiliary; Doyle Hanson, D.D.S., of Holbrook; Eugene Savoie, D.D.S., of Tucson, and myself as ex-officio member of the Committee. This committee will be responsible for the program, menu and selection of the speaker. It might be of interest to the Scientific Assembly Committee to know that we are attempting to obtain another noted Senator again, specifically Senator Dirksen if he will be available. If not, we may conceivably go this year to one of the noted columnists, and in this respect Art Buchwald has been mentioned. The American Medical Political Action Committee is assisting us again this year in securing a suitable speaker; and, I am confident that we will put on a program as successful as our 1968 program. It is, however, still somewhat early to have the definite arrangements fully taken care of."

COMMUNICATIONS

Aetna Life & Casualty Co.

Letter dated August 7, 1968, requesting participation at the annual meeting.

It was recommended that a report on Medicare be made by Aetna Life & Casualty Company during the first House of Delegates meeting scheduled for 2:00 p.m. on Tuesday, April 22, 1969.

Barrow Neurological Institute

Letter dated September 6, 1968, from Richard A. Thompson, M.D., offering participation of BNI in the 1969 annual meeting.

It was agreed that BNI participation should be encouraged and that it could be used to round out the program after details are received from Tulane University School of Medicine.

OTHER BUSINESS

Commercial Booth Sales

Mr. Robinson reported that all 40 commercial booth spaces have been sold. Five firms are on the waiting list for additional booth space openings.

AMA — President-Elect

Dr. Sattenspiel announced that Gerald D. Dorman, M.D., President-Elect of AMA, has accepted our invitation to speak to the General Session on Tuesday, April 22, 1969, at 3:00 p.m.

MEETING ADJOURNED AT 5:45 P.M.

John P. Heileman, M.D.
Secretary
By Bruce E. Robinson
Assistant Executive Secretary

PROFESSIONAL COMMITTEE

Meeting of the Professional Committee of the Arizona Medical Association, Inc., held Sunday, October 13, 1968, in the Convention Center of the Safari Hotel, 4611 North Scottsdale Road, Scottsdale, Arizona, convened at 11:07 a.m., William G. Payne, Chairman, presiding.

ROLL CALL

PRESENT: Drs. Antos, Robert J.; Baker, Earl J.; Cutts, Robert I.; Ganelin, Robert S.; Helme, William B.; Kohl, Jr., Harold W.; Payne, William G., Chairman; Wagner, Albert G.

STAFF: Messrs. Carpenter, Robert, Executive Secretary; Robinson, Bruce E., Assistant Executive Secretary.

GUEST: Dr. Spendlove, George A., Commissioner, Arizona State Department of Health.

EXCUSED: Drs. Dexter, Richard L.; Dudley, Jr., Arthur V., President; Flynn, Richard O., President-Elect; Heileman, John P., Secretary; McDaniel, W. Shaw; Melick, Dermont W.; Rhu, Jr., Hermann S.; Schaller, Donald F.; Wood, MacDonald.

MINUTES

Approved Minutes of the Professional Committee Meeting held June 9, 1968.

FINANCE

Reported, as of August 31, 1968, out of a total (1968) Budget of $5,000.00, there has been expended $1,951.74. Take note. RECEIVED.

BOARD OF DIRECTORS — ACTIONS

The Board of Directors of The Arizona Medical Association, Inc., in meeting held July 14, 1968, considered the following subjects and acted as indicated:

VISION & HEARING SCREENING
PRE-SCHOOL CHILDREN

Endorsed the program of the Arizona Opthalmological Society, without financial obligation; recommending that screening of pre-school children include both vision and hearing. RECEIVED.

It was stated that in discussion by the Section on Public Health it was the expressed feeling that the vision screening of pre-school children carried on by the Arizona Ophthalmological Society was a good program, believed to be as good, if not better than, the Minnesota effort, there having been more children competently screened the first year with less consultants and staff. RECEIVED.

As regards the hearing program in Maricopa County, it is felt it is adequate for first graders, operating through the Arizona State Department of Instruction, but should be extended to include pre-school children. NO ACTION.

INTRAVENOUS ADMINISTRATION OF
FLUIDS BY PROFESSIONAL R.N.

Approved the Joint Statement by the Arizona Medical Association (on recommendation of the Professional Committee), the Arizona Hospital Association, and the Arizona State Nurses' Association on the intravenous administration of fluids (including blood) by Professional Registered Nurses practicing in the State of Arizona. RECEIVED.

COMMUNICATION SYSTEMS SURVEY

Without financial obligation, approved a proposed survey of all communications systems operating throughout Arizona, to include equipment in existence, its capabilities, needs for the future and budget requirements, leading to a coordination of the communication systems. RECEIVED.

AIR MEDICAL EVACUATION SYSTEMS (AMES)

Approved the report on program evaluation, program management concept and budget, prepared by the Division of Industrial Design and Technology of Arizona State University, associate with the Air Medical Evacuation System (AMES) demonstration project. Appointment of membership of a Steering Committee awaits the pleasure of this Association. Nominations are awaited.

RECEIVED.

AHA EDUCATIONAL COORDINATING COMMITTEE

Approved the appointment of Howard N. Kandell, M.D. (Phoenix), to serve, as representative of this Association, on the Educational Coordinating Committee of the Arizona Hospital Association. RECEIVED.

PERINATAL & MATERNAL MORTALITY REPORT

Appropriated an amount not to exceed $500.00 to prepare the final report relating to study conducted in the field of perinatal and maternal mortality over the past four years with the aid, cooperation and financial assistance of the Arizona State Department of Health. RECEIVED.

SECTION REPORTS

Aging and General Medicine

HEARING SCREENING PRE-SCHOOL CHILDREN

Report previously given, following reported action of the Board of Directors, by the Section on Public Health.

OBESITY

Presented resolution adopted by the AMA House of Delegates in meeting held in San Francisco, June last, in the matter of danger involved in the use of potentially dangerous drugs in the treatment of simple obesity. For the record, following is the Resolution numbered 14:

> "Whereas, Increasing effort is being put into the search for new methods of regulating medical practice with the admirable intent of insuring the public a uniformly high quality of medical care; and
>
> Whereas, There is a continuing need for medicine to demonstrate its competence in protecting the public against hazards and unsound practice; and
>
> Whereas, There is a significant and increasingly publicized problem with a certain minority of physicians who limit their practice to the treatment of obesity; and
>
> Whereas, The use of digitalis, prolonged diuretic administration and toxic doses of thyroid, as well as other potentially dangerous therapeutic modalities, have no rational basis in the treatment of obesity alone; and
>
> Whereas, The dispensing of such potent drugs for uncomplicated obesity is to be condemned; therefore be it
>
> **Resolved,** That the American Medical Association continue its efforts to safeguard and inform the public with respect to the treatment of obesity; and be it further
>
> **Resolved,** That the Board of Trustees report back to the House of Delegates on progress made at the Miami Clinical Convention in December."

It was recommended that the content of this resolution be recorded in Arizona Medicine for the information of the membership.

DIABETES DETECTION

Information has been received from the American Diabetes Association advising of materials available in support of the conduct of a Diabetes Detection Program. NO ACTION.

ALCOHOL & DRUG ABUSE

Dr. Kohl reported receipt of a letter received from the Department of Transportation, Washington, D.C., relating to a comprehensive study of Alcohol and Highway Safety problems transmitted to Congress in August last by the Secretary of Transportation, Allen Boyd. The use of alcohol by drivers and pedestrians leads to some 25,000 deaths in a total of at least 8,000 crashes in the United States each year. Specially tragic is the fact that much loss in life, limb and property damage involves completely innocent parties. For information.

In the matter of Drug Abuse, AMA points need for an intensive public education program because of the severity of the problem and confusion which exists, in many quarters, about whether certain drugs are truly dangerous. Such campaign can be most effectively directed by physicians, in close cooperation with pharmacists, since members of the two professions are keenly aware of the problem and its complexities. A Drug Abuse Information kit is filed, helpful in any such campaign. For information.

Allied Medical Groups

PLANNED TECHNICAL EDUCATION

It was reported that Dr. James E. Gibson, Program Developer — Research Associate, Maricopa County Junior College District, had left Arizona and would not be present this morning. He had sought opportunity to address the assembly to present the Planned Technical Education Program in the areas of nursing (pre-practical) and surgical technics, ultimately to enter the field of radiological technicians, etc. RECEIVED.

ACUTE CARDIAC CARE JOINT STATEMENT

Dr. Helme presented and read his report as regards the Joint Statement on Acute Cardiac Care prepared and submitted by the Arizona State Nurses' Association. The Board in meeting held November 12, 1967, emphasis having been placed on the "properly trained and competent to perform" nurse under direction of the physician, concurred in the then expressed view of the Professional Committee of the importance of establishing legal responsibility in these cases, such responsibility to be carefully spelled out; and that all physicians in the state working in hospitals in this area be similarly informed in order that they may know exactly where they stand. Arizona Hospitals involved were communicated with and asked for comment. The responses were summarized.

It is felt this is a legal rather than a medical problem. In acute cardiac care units operated in hospitals, a substantial amount of medical responsibilty necessarily is delegated to the nurse. It may be perfectly alright for the Association to say: this is a good model of rules and regulations promulgated in this instance for your hospital, but the question of legal responsibility is not one that we could resolve or make recommendations. Nurses, of course, should have special training and there should be understanding between the physician and the hospital of what they can do.

St. Luke's Hospital (Phoenix) in its response, submitted a rather detailed statement relating to the subject dealing with patient care wherein it is expressed that the attending physician shall retain responsibility for the patient. Obviously, much thought was given to the preparation of this document.

It was regularly moved and unanimously carried that it be the recommendation of the Professional Committee

to the Board of Directors that this document (joint statement on acute cardiac care submitted by ASNA), in its opinion, is inadequate and obscure, that the statement of St. Luke's Hospital in this regard appears better; further, that it is the feeling of this Committee that the legal aspects thereof must be determined by counsel, not by it; and that a document similar to that of St. Luke's Hospital would appear more appropriate.

ArMA-ASNA Liaison

MEETINGS

Dr. Payne reported that the Flagstaff meeting scheduled for July 20, 1968, was cancelled because of lack of attendance. It has been rescheduled to be held in Tucson, Saturday, October 19, 1968.

NURSES' RECOGNITION DAY

Attention was called to the proposed promotion of "Nurses' Recognition Day" within communities in recognition of their significant health care contributions continuously being made and their dedication to the task, said program being urged by the American Medical Association. The Chairman suggested the desirability of making available funds, possibly in the form of a cash award to an outstanding nurse, or scholarship to help finance a student's education, contributed by the Arizona Medical Association, however they want to handle it.

Report of the joint meeting of the AMA and ANA will be discussed at the Saturday next meeting (Dr. Payne attended this meeting); together with discussion on nurse education and availability of nurses. The three Arizona Universities have baccalaureate nursing programs; the Glendale, Mesa and Phoenix Community Colleges have affiliate nursing programs for RN registrations; and then there are the LPN programs, in addition to the hospital diploma schools which appear to be phasing out.

It was determined to support the chairman to the extent of available funds in the promotion of nursing.

Athletic Medicine

REPORT

In the absence of the Chairman, no report submitted.

Disaster Medicine

MEETINGS

Looking over the poor attendance at this morning's meeting, and while this subject is not exactly Disaster Medicine, though the title is appropriate, Dr. Baker raised for discussion the matter of future meeting dates.

With the exception of Dr. Payne, he stated he had been attending Professional Committee meetings longer than anyone else present. At this point in the meeting, we do not have a quorum; further, while we have always given special consideration to out-of-city members, only one such is present this morning and that is Dr. Cutts from Tucson. It is his strong feeling that Sunday meetings should be discontinued; that arrangements should be made to hold early breakfast meetings and possibly conclude the agenda by one o'clock; and that they should be held on possibly Saturdays. It was felt that the business of this Committee is too important to have decisions made by only a small fraction of the total membership. Matters assigned to the various Sections are not being handled in the absence of the respective chairmen, and lately this goes on meeting after meeting. It is understood this situation is not singular to this Committee. The time has come to take action if the business of the Association is to be conducted as it should be.

Dr. Payne reviewed the many innovations tried in the conduct of the meetings, Section assignments, request for written reports to speed up the proceedings, etc., which have not produced the desired results. It has been suggested meetings be scheduled on a week-day which will give the members the weekend free of meetings in order that they may spend the time with their families, as much as possible. This did not appear to be an insurmountable possibility and is being carried out by other Associations in other areas of the country. Reimbursement for travel and lodging expenses of out-of-city members was likewise discussed. It was the hope that the Board of Directors, as a matter of policy, would introduce a resolution during the last annual meeting for House action decreeing there would be no further Sunday meetings, but this did not materialize. It should be considered for next year.

It was regularly moved and unanimously carried that the next meeting of this Committee scheduled to be held Sunday, December 15, 1968, be cancelled, and that the next meeting of this Professional Committee, as an experiment, be held on Saturday, December 14, 1968, to convene at 1:00 p.m., with luncheon, the business of the session to commence during luncheon and continue to its conclusion not later than 5:00 p.m. when the room must be vacated.

Emergency Care

REPORT

In the absence of the Chairman, no report submitted.

AMES STEERING COMMITTEE

It was observed Dr. Schaller, by letter dated August 28, 1968, addressed to Dr. Dudley, ArMA President, proposed the following members to comprise a Steering Committee associate with the Air Medical Evacuation System: Frederick E. Beckert, M.D. (Pheonix); Paul B. Jarrett, M.D. (Phoenix); Howard H. Johnston, M.D. (Phoenix); Sherman W. Thorpe, M.D. (Mesa); Robert D. Martin, M.D. (Tempe); James L. Schamadan, M.D. (Tempe); and Kenneth L. Huffman, M.D. (Mesa). Representation from Tucson was also suggested. RECEIVED.

TRAFFIC SAFETY COORDINATING COUNCIL

Likewise, it was observed that Donald F. Schaller, M.D. (Phoenix) has been appointed by the Governor to serve as a member of the Governor's Traffic Safety Coordinating Council, representative of the medical profession and his position as a medical officer in Civil Defense. RECEIVED.

Industrial Health

MEMBERSHIP

With the resignation of Jack D. Fatheree, M.D. (Phoenix), Chairman of the Section on Industrial Health, accepted by the Board of Directors in meeting held September 8, 1968, appointment of a replacement is being awaited at the pleasure of the Board. It is understood Maricopa County Medical Society, at its request, is being given the opportunity to present nominations.

REPORT

In the absence of a Chairman, no report submitted.

Medical Education

MEMBERSHIP

As previously reported, Dermont W. Melick, M.D., a member of the Professional Committee 1966-69, designated Chairman of this Section, has previously expressed his desire to be relieved of this assignment. Oscar A. Thorup, Jr., M.D., U. of A. College of Medicine, suggested as a replacement, declines appointment. NO FURTHER ACTION.

MEDICAL & PARA-MEDICAL SHORTAGES — STUDY

In the absence of a chairman, no report submitted. Reschedule next meeting.

MEDICAL EDUCATION CONFERENCE — CHICAGO

Dr. Payne reported that inasmuch as Dr. Melick is unable to attend the scheduled National Conference on Continuing Medical Education, sponsored by the AMA, to be held in Chicago, November 12 through 14, 1968, at Dr. Melick's suggestion, he has authorized attendance by Boyden L. Crouch, M.D. (Phoenix), a member of the Section on Medical Education, supervising the TV Medical education productions in Arizona. APPROVED.

LEGALITY OF INTERNSHIP PRIOR TO GRADUATION

In the absence of a chairman, no report submitted. Reschedule next meeting.

MEDICAL TV PROGRAM APPROPRIATION

In the absence of a chairman, no report submitted. Reschedule next meeting.

MEDICAL TV SEMINAR EXPENSE AUTHORIZATION

Boyden L. Crouch, M.D., Associate Coordinator, Continuing Education, Arizona Regional Medical Program, and member of the Section on Medical Education, supervising the TV Medical Education productions in Arizona, submits for approval, an expenditure for one-half transportation ($68.25) of Dr. Wayland Hull of NASA, Manned Spacecraft Program in Houston, who was invited and appeared during the Television Seminar held September 21, 1968, Del Webb TowneHouse, Phoenix. The Arizona Regional Medical Program will assume the other half of this charge. Report thereon filed. APPROVED.

Medicine and Religion

REPORT

Dr. Wagner stated that while he was unable to make the last Professional Committee meeting, he had forwarded by mail his report, special delivery, to the Chairman, Dr. Payne, at his residency. Unfortunately, it was not delivered until the Tuesday following the Sunday meeting held June 9, 1968. Following is my report:

I. Organization of Committee

A. **Composition** — (1) Geographical Central Committee — composed of members of state committee living in Maricopa County plus chairman of Maricopa County Committee of Medicine and Religion. (2) Entire State Committee — in addition to duly appointed members of state committee, will include all chairmen of County Committee of Medicine and Religion.

B. **Attendance — Quorum** — All members are urged to attend all meetings. Members present at any meeting will be considered a quorum, with authority to carry on the business of the entire state committee.

C. **Meetings and Minutes** — Meetings will be held at least quarterly, including one at the time of the ArMA annual meeting. Notification of all meetings and copies of all minutes will be mailed to each committee member.

II. Reports

A. **Martin List, M.D.** — Vice Chairman, reported to State Committee Meeting 10/10/68 on — (1) Area Meeting of state chairman in San Francisco, March 9, 1968. (2) National Meeting of the Lutheran Medical Mission Association held at Estes Park, Colorado, September 23-27, 1968. In addition to discussing the excellent program in some detail, Dr. List mentioned that several doctors in attendance were not aware of the AMA Department of Medicine and Religion and its committees.

B. **The Rev. Leon Glenn,** Secretary, Chaplain of Scottsdale Baptist Hospital, reported his participation in a panel in Tucson, October 7, 1968, "The Hospital Ministry." In addition to the interest displayed during the panel, both physicians and clergymen expressed lack of knowledge of the Committee of Medicine and Religion in Tucson and of desire to develop an active group in that city.

III. Plans

A. **Statewide**

(1) Continuation of effort to stimulate activities of County Committees of Medicine and Religion. The first meeting in Mohave County, Ray Hammer, M.D., Chairman, will be held at the regular county medical society dinner meeting Tuesday, October 15, 1968. In addition to clergymen, the wives of doctors and pastors have been invited. The chairman and secretary of the State committee and their wives plan to attend and present this introductory meeting. (Note: Because of the accidental death of Chaplain Glenn's son on 10/10/68, the Glenns will not attend. The Rev. and Mrs. William Pebler have agreed to substitute for the Glenns. Pastor Pebler is a member of the Maricopa Society of Medicine and Religion.)

(2) During 1968-69, three or four other kick-off meetings are being planned in various communities of the state.

(3) In 1969 a seminar on cancer, involving Medicine and Religion, in Phoenix, by combined effort of this committee and the Arizona Division of The American Cancer Society is being planned by Karl Voldeng, M.D., committee member.

(4) A request was made by The Maricopa Society of Medicine and Religion at its meeting of September 30, 1968, that a statement of Procedures and Ethics be written. It is the impression of that Society that such a statement would help clarify and improve interrelationships between the clergy and physicians. Such matters as how

a clergyman may offer his services to a physician, when and how a physician may contact his patient's clergyman, do's and don'ts for the clergy in the hospital, will be included. It is hoped that such a statement or series of statements will be written up and approved during 1969. Assistance to the Maricopa Society in this matter will be provided by both the ArMA Committee and the AMA department of Medicine and Religion.

(5) Again a request will be made to the ArMA Program Committee for a place on the program of the annual meetings next spring.

(6) The state committee requests that booth space may again be made available at the annual meeting in April 1969.

B. **Maricopa County**

(1) The Maricopa Society of Medicine and Religion has set up its most ambitious program to date for 1968-69 — 1 meeting per month from September thru May except in December. There will be 6 dinner meetings at St. Luke's Hospital and 2 breakfast meetings at Good Samaritan, as follows:

September 30 — Dinner Meeting — "The Supervising Nun and Nurse Speak Out."

October 30 — Dinner — The Hospital Chaplain, Is He Necessary?

November 30 — Breakfast — The Arizona Abortion Law.

No December Meeting.

January 30 — Dinner — Contraceptives & the Coed.

February 22 — Breakfast — Treating the Whole Patient — The Christian Science Point of View.

March 31 — Dinner — Suicide.

April 30 — Dinner — Use and Abuse of Tranquilizers, Mood Elevators and Sedatives.

May 21 — ANNUAL MEETING with wives as guests — Teen-Age Morality.

(2) Chaplain Leon Glenn reported a series of seminars for the lay membership of the First Congregational Church, Phoenix, Shelby Lee, Pastor, entitled "Life Situation Seminars." Chaplain Glenn will participate in the Seminar entitled "Relating to the Sick."

(3) An all-day Seminar is planned by the Mental Health Clinic for November 18, 1968, at Scottsdale Baptist Hospital. This will be primarily for clergymen, to assist them in recognizing and dealing with problems of mental health.

C. **National**

(1) Letter of the Reverend Dr. Paul B. McCleave dated 7/19/68 is read and discussed briefly. Titles of his report to Charles Hudson, M.D., new Director of the new Division of Health Service are read. Plans for the new film "A Storm, A Strife" are noted.

(2) Plans for aids to State and County Committees are described.

(3) Attention is directed to a brochure by the Illinois Committee, "What every doctor should know about the religious needs of his patient."

IV. Requests to the Professional Committee

A. Approval of the State Committee Organization as noted above.

B. Approval of an annual budget of $800: to include:

(1) Cost of shipping display for booth at ArMA Meetings next April.

(2) Payment of about ½ the cost of travel of clergy appointed by the chairman to state organizational meetings. (No instate expenses for M.D.'s)

(3) Out of state travel expenses for Chairman or his designate to national and area meetings.

(4) Miscellaneous organizational and correspondence expenses.

Summary:

Purposes of the Committee of Medicine and Religion summarized as:

(1) To bring about improved and frequent one-to-one meetings of the physician and the clergyman for the benefit of his patient and his parishioner.

(2) To encourage regular group meetings involving both disciplines in discussion of common problems.

It was regularly moved and unanimously carried that the committee organization, as proposed, be approved.

It was regularly moved and unanimously carried that the budgeted item for shipping display to the 1969 ArMA Annual Meeting (estimated cost under $100.00) be approved.

It was regularly moved and unanimously carried that the Budget request of $800.00, to include the items listed in the report, be approved.

HAROLD W. KOHL, JR., M.D., ENTERED THE MEETING AT THIS POINT.

Mental Health

MEMBERSHIP

The membership of the Section on Mental Health, under the Chairmanship of Robert I. Cutts, M.D. (Tucson) will continue for the fiscal year 1968-69 including: Hal J. Breen, M.D. (Phoenix); Richard H. Bruner, M.D. (Phoenix); David S. Burgoyne, M.D. (Phoenix); Gabriel L. Cata, M.D. (Tucson); Hubert R. Estes, M.D. (Tucson); T. Richard Gregory, M.D. (Phoenix); John H. Jarvis, M.D. (Mesa); Duane K. Tevis, M.D. (Phoenix); Karl E. Voldeng, M.D. (Phoenix); and Albert G. Wagner, M.D. (Phoenix).

PRIVILEGED COMMUNICATION

In meetings of the Professional Committee, one held on January 10, 1965, the other July 25, 1965, the subject of "privileged communication" was discussed. Review of the statutes pertaining to privileged communication, as applied to psychiatrists, specifically, and doctors of medicine, generally, appeared desirable leading to the introduction of a model law, if indicated. It was recognized this would be a costly undertaking and that possibly the Arizona Psychiatric Society, being primarily interested, should be called upon to bear the expense.

Counsel, by letter dated April 1, 1964, gave a cursory review of four Arizona statutes bearing on privileged communication i.e. ARS § 12-2235; ARS § 12-2236; ARS § 13-1802.4; and ARS § 23-908C. It would appear that there is some merit to the American Psychiatric Association's position. Otherwise stated, it would appear

that there is a serious doubt, especially in civil cases, as to whether communication between a psychiatrist and his patient would be considered privileged.

Dr. Cutts reported that for some reason or other preoccupation, the subject had not been pursued. Statutes governing in Connecticut and Maryland were reviewed resulting in the following suggestions to be incorporated in the drafting of legislation for Arizona:

The patient should have the privilege in regard to:

1. Any communication between patient and physician arising out of the professional relationship. This includes any knowledge on the part of the physician gained by interview, examination, or any other means arising out of their professional relationship.
2. Any communication from other people about the patient, such as patient's family, friends or others. (In Maryland law the term "authorized representative" covers this aspect.)
3. Any communication from patient or authorized representative to any other person associated with the physician professionally. Nurse, office help (secretary, etc.) or other professional or non-professional personnel who are in any way involved with the physician in diagnosis or treatment of the patient.
4. Other patients in group psychotherapy or any other form of therapy in groups, such as psychodrama, occupational therapy, etc.
5. Provision for guardian to assert privilege if patient incompetent.

EXCEPTIONS

Privilege should not apply in the following:

1. When it is necessary to disclose such communication for purpose of placing patient in a facility for mental illness, by commitment, certification, or otherwise.
2. Examination ordered by the court, providing patient has been informed that the communication would not be privileged.
3. When patient introduces his mental condition as an element of his claim or defense — or when such is introduced in court after patient's death.
4. Malpractice or other (i.e. assault) action against the physician by the patient.

It is desirable to have these suggestions reviewed and evaluated by counsel, if this Committee approves, and if legal expense is involved for implementation, Dr. Cutts will take the matter back to the Arizona Psychiatric Society for further consideration. It was mentioned that clinical psychologists and attorneys are currently covered in Arizona.

It was regularly moved and unanimously carried that it be the recommendation of the Professional Committee to the Board of Directors that these suggestions be referred to counsel for evaluation and determination as to whether or not it is worthwhile to work toward introduction of legislation in Arizona to achieve the objective.

MENTAL HEALTH THERAPY

The concern of a number of members of the Section on Mental Health is the care of Arizona citizens in need of mental health treatment, it was reported. Approximately $150,000.00 is made available to the fourteen counties, considered woefully deficient. Patients considerably in excess of six thousand are now being seen annually at established locally operated clinics, many of whom would need hospitalization without such services and at substantially more cost. The Legislature is being asked to increase the appropriation for this purpose in 1969-70. RECEIVED.

WILLIAM B. HELME, M.D., LEFT THE MEETING AT THIS POINT.

Perinatal and Maternal Mortality

NURSE-MIDWIFERY

While in the absence of the Chairman, no formal report was submitted, it is anticipated Dr. Rhu will speak on the subject at the next meeting of this Committee.

REPORT

Authorized request of the Board of Directors for an additional appropriation not to exceed $500.00, if found necessary, to be allocated to the completion of the final report on the study of perinatal and maternity mortality.

MEETING ADJOURNED FOR LUNCHEON AT 1:00 P.M.

* * * * *

MEETING CONTINUED IN THE FRENCH QUARTER OF THE SAFARI HOTEL DURING LUNCHEON, ALL MEMBERS PRESENT DURING THE MORNING SESSION RESPONDING "AYE" TO THE ROLL CALL, EXCEPTING WILLIAM B. HELME, M.D., WILLIAM G. PAYNE, M.D., CHAIRMAN, PRESIDING.

Poison Control

REPORT

Dr. Antos reviewed the activity associate with his assignment involving poison control and problems encountered as regards organization and services. It was agreed that the membership of his Section should include the directors of the various poison control centers; that the chairman should obtain their names and submit them to the Committee for appointment; and that there be established a program or seminar to be held at least once a year to which these directors and any others interested could attend and be briefed in this important area of practice. Organizing poison control centers and training attendants (technicians or nurses) certainly falls within the scope of activity of this Section to the extent of developing formats and prescribed course of training required. This latter could then be turned over to the hospital for implementation. Development of wall charts or other acceptable devices to alert the physician what to look for and what to give would be of inestimable value. In instances where the chairman is called upon to advise course of treatment because of his expert knowledge in this area and then is expected to care for the patient, certainly he should be expected to submit a statement covering "fee for service" rendered as a consultant. The operation of poison control centers is to provide information only to the physician and not to render patient care.

Dr. Antos was commended for his work on poison control and the full cooperation of the Sections on Disaster Medicine and Emergency Care were extended to further assist him in his endeavors.

Public Health

MEMBERSHIP

Charles L. Levison, M.D. (Phoenix) appointed a member of the Section on Public Health to serve as Chairman of the Rural and Migrant Health subcommittee. APPROVED.

STANDARD HEALTH RECORD FORM

Dr. Ganelin reported the Section on Public Health had met and will continue to meet. A standard health record form will be devised and then, further contact will be made with the Colleges and Universities. RECEIVED.

CLINICAL LABORATORIES LICENSING & REGULATION

Dr. Spendlove briefly reviewed the rough draft of legislation proposed to develop, establish and enforce standards; provide qualifications for a director; call for proficiency testing; give responsibility to Board of Health; and establish an Advisory Council to consist of an MD-Pathologist, an Internist, a General Practitioner, an Osteopathic-Pathologist, a Hospital Administrator, a Laboratory Director (non-medical), a Technologist, a lay-member associate with laboratory, and the Commissioner of Public Health, as ex-officio. The proposed Act calls for laboratory inspection; a fee for license of not over $200.00; rules and regulations which relate to the Director's qualifications; operations; qualifications of personnel; equipment; minimum standards for proficiency testing; prohibits fee-splitting, solicitation or advertising; defines a clinical laboratory as any institution which examines tissues, secretions, and excretions of the human body, misfunctions, diagnosis, etc.; exempts the United States Government, Doctors of Medicine, Osteopaths, Dentists; out-of-state laboratories required to be licensed if they ship into state; reciprocity provided, etc. Considerable discussion ensued.

It was regularly moved and unanimously carried that this Professional Committee recommend to the Legislative Committee that provision be made for groups of physicians to utilize their own laboratory for their own work without licensure; and that such legislation be drawn up.

PHYSICAL EDUCATION IN SCHOOLS

It is recognized the programs of physical education in the elementary schools where they exist are inadequate. Steps are being taken by the Arizona Department of Public Instruction to improve or establish them where non-existent. The Section supported the extension of the physical education programs as suggested by Mr. Frank Williams. Boyd H. Metcalf, M.D. (Scottsdale) likewise expressed interest in this matter.

RURAL HEALTH CONFERENCE

The 22nd National Conference on Rural Health sponsored by AMA is scheduled to be held in Philadelphia, March 21 and 22, 1969. It is the feeling the new chairman, Dr. Levison, should attend this meeting and funds are requested estimated at $410.00. APPROVED.

PKU TESTING

PKU testing not being done routinely since the Arizona State Department of Public Health discontinued its laboratory services in this area. Attention was directed thereto through release of a recent report that only 50% of newborns are being tested; however, there has been an appreciable change since then as Good Samaritan is now testing routinely and the statistics will continue to increase when Maricopa County General undertakes such testing soon. It continues to be the position of this Section that legislation to require such testing should be avoided. Testing should be implemented through hospital committees. Stimulation should come from physicians within such committees and this has been already called to their attention, the Arizona Hospital Association, and the Arizona Pediatric Society. Further stimulation should be attempted through ArMA calling attention to the desirability of PKU testing for all newborns in the state.

HEARTOMETER

Equipment called the "Cameron Heartometer" allegedly records the pulse rate and diastolic and systolic blood pressures. A license has been applied for through the City of Tucson. It is understood this matter has been referred to the Board of Medical Examiners of the State of Arizona. If such equipment were used by a licensed physician, there would be no violation of the Medicine and Surgery Act; otherwise, it would appear there would be and the Attorney General will so rule. Dr. Payne stated that the proposed report form to be used does provide for comment as to "normal" or "abnormal" reading which is diagnosis. Inasmuch as the problem is in the hands of the Board of Medical Examiners there is no need for further comment or action.

IMMUNIZATION SCHEDULES

Dr. Spendlove displayed the revised immunization schedules prepared by staff of the Preventive Medical Services Division of the Arizona State Department of Health. While it does not represent a unanimity of opinion, it certainly is an expressed consensus. It will be reproduced for distribution in two forms i.e. wall size and booklet. Arizona Medicine has also agreed to reproduce it in a subsequent issue. APPROVED.

TETRACYCLINE OINTMENT

The Arizona State Board of Health on August 20, 1968, unanimously approved the use of Tetracycline ointment as an alternative to Silver Nitrate in the eyes of newborn babies for prevention of Gonorrheal Ophthalmia. Adoption of this alternative requires no change in the present regulation. All interested parties will be notified and this action will be publicized in Arizona's health publication and other news media such as ArMA Medical Memos. All hospitals will be appropriately notified.

The Committee acknowledged with enthusiasm this change. Implementation will be at the discretion of the individual hospitals.

COMMUNITY HEALTH WEEK

In cooperation with the American Medical Association in promotion of the Sixth Annual Community Health Week, October 20-26, 1968, the theme: "Teaming Up for Better Health," Dr. Spendlove reported he had communicated with all the Directors of the local Health Departments recommending participation and direction as to where promotional materials are obtainable. Emphasis will be placed on "drug abuse," "physical fitness" and "expanding career opportunities in medicine and allied fields." It was felt that "smoking" should also be included. RECEIVED.

DIETETIC INTERNSHIP

The University of Arizona, Division of Food, Human Nutrition and Dietetics, is working cooperatively with the Arizona Dietetic Association, the Arizona State Department of Health and selected health facilities throughout the state to establish a dietetic internship for Arizona. The program will emphasize therapeutic nutri-

tion and nutrition education. The dietician's education will be: (a) B.S. or B.A. Degree in Nutrition or Dietetics; (b) Dietetic Internship (50 weeks — 12 units); and (c) Graduate Course Work (18 units). The combined program will give a Master of Science Degree in dietetics with the total internship to be completed in 18 months. Minimum standards have been established by the American Dietetic Association. Title of the program is: "The University of Arizona and Arizona Health Care Facilities Dietetic Internship." ArMA endorsement is sought.

It was regularly moved and unanimously carried that this Professional Committee recommend to the Board of Directors that it concur in the findings and recommendations of this program and offer encouragement and support thereto in the establishment of a dietetic internship for Arizona.

ENVIRONMENTAL HEALTH SUBCOMMITTEE

Dr. Ganelin, by letter dated October 7, 1968, addressed to Dr. Bernard E. Levine, M.D. (Phoenix), member of his Section on Public Health, suggested that he organize a Subcommittee on Environmental Health. Great need exists for an actively functioning committee in environmental health, particularly in the area of air pollution, under his chairmanship and direction. RECEIVED.

Safety

MEMBERSHIP

Peter M. Cole, M.D. (Scottsdale), Howard H. Johnston, M.D. (Phoenix), Henry P. Limbacher, M.D. (Tucson), and Richard T. McDonald, M.D. (Flagstaff), have accepted membership appointment to this Section on Safety. Albert G. Wagner, M.D., has declined because of his many other commitments.

REPORT

In the absence of the Chairman, no report submitted.

Woman's Auxiliary

REPORT

In the absence of the Chairman, no report submitted.

MEETING ADJOURNED AT 3:30 P.M.

John P. Heileman, M.D.
Secretary
By Robert Carpenter
Executive Secretary

LEGISLATIVE COMMITTEE

Meeting of the Legislative Committee of The Arizona Medical Association, Inc., held Sunday, October 20, 1968, in the French Quarter of the Safari Hotel, 4611 North Scottsdale Road, Scottsdale, Arizona, convened at 10:10 a.m., Arthur R. Nelson, M.D., Chairman, presiding.

ROLL CALL

PRESENT: Drs. Craig, Carlos C.; Dudley, Jr., Arthur V., President; Griess, Donald F.; Heileman, John P., Secretary; Holbrook, John P.; Nelson, Arthur R., Chairman; Oakley, John E.

COUNSEL: Mr. Jacobson, Edward.

STAFF: Messrs. Carpenter, Robert, Executive Secretary; Robinson, Bruce E., Assistant Executive Secretary; Boykin, Paul R., Executive Secretary — BOMEX.

GUESTS: Drs. Bendheim, Otto L., Secretary-Treasurer — BOMEX; Koerner, Ralph L. (D.D.S.), Chairman — Legislative Committee, Arizona State Dental Association; Spendlove, George A., Commissioner — Arizona State Department of Health; Mr. Park, Robert K., General Counsel — Administration —ICA.

EXCUSED: Drs. Bennett, Chester G.; Caskey, John H.; Clemens III, William J.; Davis, C. Truman; Flynn, Richard O., President-Elect; Henderson, Charles E.; Kahle, John F.; Lyle, William H.; Oliver, Robert J.

MINUTES

Approved minutes of the Legislative Committee meeting held December 17, 1967.

FINANCE

Reported as of September 30, 1968, out of a total (1968) Administrative Budget of $600.00, there has been expended $591.64; the Legal Budget for 1968 reflects a "legislative" expenditure of $4,903.38 out of a total of $6,200.00, and "other" expenditures of $3,005.29 out of a total of $3,800.00.

ICA PATIENTS — RULE NO. 59-A — FREEDOM OF CHOICE (TUCSON CLINIC)

Counsel advised, with respect to the alarm of the Tucson physicians concerning the use of the Tucson Clinic by certain industrial employers, the background of the law (highly summarized) is as follows:

"(a) The employer has the absolute duty to provide first aid for an employee injured on the job.

"(b) The employer has a statutory right to have an employee examined by a physician chosen by the employer in order to determine the nature and extent of the employee's injuries.

"(c) ARS § 23-1087E. provides that if the medical treatment furnished by the employer is such that there are reasonable grounds to believe that the health, life or recovery of the employee is endangered or impaired, the Commission, on application of the employee or on its own motion, may change physicians. The possible implication here is that the employer might have the right to designate the physician.

"(d) The Commission has had a long standing rule (Rule 59A) which, in fact, seems to require the employee to go to a physician selected by the employer.

"(e) Over the years the rule has been somewhat ignored and the only employers who have been taking advantage of it by and large, are those with medical departments of their own.

"(f) The laws of other states are now being studied by the Commission and they range all the way from California's position, which permits the employer to have total control, to states at the other end of the range, which give real effect to the principle of free choice of physician.

"(g) The Industrial Commission, under the leadership of Bob Park and Bob Steckner, are currently reviewing all of these laws with a view to some amendment of Rule 59A which will go as far as possible in preserving the freedom of choice physician principle on the one hand, while, on the other hand, protecting the employer and the insurance companies interest in seeing that the injured employee is in competent medical hands so that he returns to service as quickly as possible."

Mr. Robert K. Park, general counsel — administra-

tion representing the Industrial Commission, on invitation of counsel representing this Association, appeared and was introduced to the assembly. Rule 59 reads as follows:

"Employee Must Follow Treatment: —

"(a) Every employee must submit to and follow the treatment and directions of the attending physician employed by his employer, or where the employer is insured for medical treatment by the employer's insurance carrier. An injured employee will not be permitted to voluntarily change from one hospital to another, or from one doctor to another, without the written authorization of the Commission.

"(b) The Commission may, upon application of the employer, employee or upon its own motion, order a change of physician or other conditions when there is reasonable grounds to believe that the health, life, or recovery of any employee is retarded, endangered, or impaired thereby, or where in the judgment of the Commission his recovery may be expedited."

Mr. Park spoke to the question reviewing Rule 59 and its interpretation by the Commission. It was pointed out that effective in January, 1969, the new Act will become effective and a new Commission will take office; likewise, it is anticipated the state will cover less insureds, commercial carriers being selected by many of the employers. Currently, ICA insures about 90%; effective January first next it is expected coverage will drop to between 60 and 70 per cent. The statutes of other states have been reviewed and comments thereon presented. "Freedom of Choice" has its advantages and disadvantages, economically. The California law provides for but one change of physician, if requested by the employee. It would appear that that provision more nearly expresses the thoughts and wishes of the doctors here, should it be determined to pursue a legislative course. It is not probable ICA will change Rule 59, especially at this time, with a new Commission taking office early in 1969. The Commission primarily has been in favor of "free choice of physician"; however, the employer has certain statutory rights. He must provide first aid and he is then entitled to require the injured employee to be examined by his physician to determine the extent of injury. Thereafter, the employee may, in writing, request to have the case treated by his physician, excepting in the instance where the employer maintains a medical department. In such instance, the employee must submit to treatment by the employer's physician(s). Mr. Park does not favor unlimited freedom of choice, but would favor the California approach. Considerable discussion ensued.

Counsel suggested that before legislation is determined the course, it might be wisdom to approach the problem on an administrative level, confer with the Industrial Commission and ascertain whether or not the problem can be resolved through a change in its rules.

It was determined that the Committee go on record favoring the administrative approach to a change in Rule 59A.

ICA-UCR

Ralph L. Koerner, D.D.S., Chairman of the Legislative Committee of the Arizona State Dental Association, on invitation, appeared before the Committee and reviewed its experience with the Industrial Commission of Arizona through the past four years, specifically as regards discussion pertaining to the establishment of usual and customary fees for dentistry. Reference was made to the efforts of the medical profession during the past legislative session endeavoring to amend the law to provide for the application of the usual, customary and reasonable fee concept associate with workman's compensation cases. It would appear with the reorganization of the Industrial Commission to become effective the early part of January next, effort should be made to achieve the objective and with coordination of effort of the two professions to this end, accomplishment might be assured.

BOARD OF MEDICAL EXAMINERS — STATE OF ARIZONA — COMPENSATION

Amendment to ARS § 32-1402F. to provide that members of the Board of Medical Examiners shall receive $100.00 for each day of actual service (rather than the $25.00 now provided) was discussed. Counsel reviewed the facts. It was determined no action would be recommended at this time.

HOUSE RESOLUTION NO. 9-68 — THERAPEUTIC ABORTION

House Resolution No. 6, adopted April 27, 1968, states: "the Arizona Medical Association does approve and support the passage of legislation by the Arizona legislature which would liberalize the indications under which a therapeutic abortion may legally be performed, as specifically outlined in S.B. 75 introduced (in the Second Regular Session of the 28th Arizona State Legislature) January 17, 1968"; further, "that the Arizona Medical Association believes that there are adequate safeguards built into this legislation (S.B. 75) to protect the public from misuse by the medical profession of these specific liberalized indications for therapeutic abortion." Dr. William E. Davis, M.D. (Tucson) who introduced this resolution was invited to be present this morning and present further his views. Unfortunately, he got as far as Casa Grande when his car developed mechanical difficulties.

In 1967, similar legislation was introduced. It failed of passage; however, it was sufficiently educational to alert the public to the need and it has been the subject of considerable public discussion ever since. A number of states since 1966 have taken action liberalizing their respective statutes, including California, Colorado, Georgia, Maryland, Mississippi and North Carolina.

The Legislative climate was reviewed. While the present prospects of having the Legislature enact such a measure do not appear promising, the route of "petition" is available and there is reason to believe the public might be in favor of liberalizing Arizona's statute. It was determined that counsel would contact someone like Bruce Merrill, Business School Professor at ASU, Tempe, who also conducts a National Opinion Research Organization to ascertain the cost to have evaluated the possible success of an initiative petition procedure at this time; also, approach the Planned Parenthood organization and ascertain its interest in this regard.

HOUSE RESOLUTION NO. 12-68—LEGAL IMMUNITY OF HOSPITAL MEDICAL RECORDS

Counsel prepared and presented a rough draft of "An Act Relating to Medical Research and Studies and Amending Title 36, Arizona Revised Statutes, by Adding a New Chapter 17," as follows:

Chapter 17. Medical Research and Studies

§ 36-1901. Medical research and studies confidential.

All information, written or oral, excepting the patient's original medical records, of the State and Local Departments of Health, [the Arizona Medical Association, Inc., its component county societies], and all accredited hospitals and their committees, used or procured in the course of research for the purpose of reducing morbidity or mortality or studies for the purpose of reviewing, evaluating, improving, or supervising the condition, care or treatment of patients, shall be confidential and shall be used only for the purpose of such research or studies.

§ 36-1902. Information relating to research and studies inadmissable as evidence; not subject to discovery; participants not required to testify.

Such information shall not be admissable as evidence in any judicial or quasi-judicial proceeding and shall not be subject to subpoena or process for any process. No person participating in such research or study shall be required to testify regarding such information in any judicial or quasi-judicial proceeding. This section shall not apply to proceedings before the State Board of Medical Examiners.

§ 36-1903. Immunity from suit for furnishing information.

No cause of action shall be against any person, absent malice, for furnishing such information in the course of any research or study referred to in § 36-1901.

§ 36-1904. Limitation of publication; identity of patient confidential.

Any publication of the results of such research or studies shall be made only for the purposes set forth in § 36-1901 and shall keep confidential the identity of any patient whose condition, care, or treatment was a part thereof.

California enacted a measure with similar purpose this year and the intent of a certain provision therein has yet to be explored by counsel. Following such exploration, he will confer with Drs. Craig, Heileman and Nelson as regards desirability for any addition(s) to the draft of bill submitted, with the view of presenting the measure in final form for approval by the Board of Directors, November 10, 1968.

STATE DEPARTMENT OF OCCUPATIONAL LICENSING — SURVEY

Otto L. Bendheim, M.D., Secretary-Treasurer, Board of Medical Examiners, State of Arizona, appeared before this Committee to express his opposition to the consolidation of all licensing boards into a State Department of Occupational Licensing. This was proposed during the Second Regular Session of the 28th Arizona State Legislature (H.B. 20); however, it failed of passage. The Arizona Medical Association through its Board of Directors expressed its opposition to the measure at that time.

Report of the Executive Secretary relating to meeting held September 11, 1968, called by the Arizona Society of Certified Public Accountants, was reviewed. The general attitude expressed among those in attendance (representing the CPA's, Nurses, Dentists, Pharmacy, Morticians — Funeral Directors, Optometrists and Medicine) seemed to conclude that a central licensing department appears inevitable in light of the drive of the Legislature to reorganize its many departments, commissions, boards, etc. It was considered wisdom by the group to give serious consideration to drafting a measure and having it in readiness for presentation at the appropriate time, compatible to the interests of the professional licensing groups.

On recommendation of counsel, it was agreed that he draft a position paper expressing the views of the medical profession, indicating those items which must be assumed by and are the exclusive responsibility of the doctors of medicine, and present for Board review at its next meeting. This position paper, on approval, could then be delivered to all of the individuals concerned at the appropriate time.

CLINICAL LABORATORY LICENSURE AND REGULATION

George A. Spendlove, M.D., Commissioner, Arizona State Department of Health, reviewed a rough draft of proposed bill dealing with licensing and regulation of clinical laboratories. Many questions were raised and suggestions offered to be included in the final draft.

H.B. 53, a similar bill, introduced in the Second Regular Session of the 28th Arizona State Legislature, January 10, 1968, failed of enactment on opposition thereto by a group of pathologists. At this juncture, it is the expressed belief that the interested parties are reasonably in accord with the proposal.

The proposed measure having been presented and likewise reviewed by Dr. Spendlove during the Professional Committee meeting held October 13, 1968, that Committee recommends to the Legislative Committee that provision be made for groups of physicians to utilize their own laboratory for their own work without licensure, and that such legislation be drawn up. The Commissioner reported this has been provided.

Health Bills

Dr. Spendlove briefly reviewed other measures proposed for introduction which would be of interest to the medical profession:

(a) Provides for the collection of fees by local health departments for such services as sewage inspection, restaurant inspection, hospital inspection, etc.;

(b) Provides for the write-off of uncollectible checks received covering statutory fees, now required to be made good by the Commissioner of Public Health, amounting to several hundred dollars over the years;

(c) Provides for the fixing of the salary of the Commissioner by the Board of Health, subject to legislative appropriation therefor;

(d) Provides for penalty by fine for violations of regulations pursuant to Article 1, Chapter 1, amendment to Section 36-140 ARS;

(e) Provides for increasing the Revolving Fund of the State Department of Health, not to exceed $5,000.00 (presently $1,000.00);

(f) Provides for the licensure and regulation of health

related facilities which include general and special hospitals, nursing care facilities and domiciliary care facilities;

(g) Provides for coverage of employees accidentally exposed to diseases;

(h) Provides for authorization by a minor to give valid consent to the furnishing of treatment for venereal disease by a licensed physician;

(i) Provides for the regulation of manufacturing, repairing, renovating, sterilizing, selling and leasing of bedding;

(j) Provides for the establishment of criteria, rules and regulations relating to air pollution;

(k) Provides for permission to sell syringes and needles; a prescription; and

(l) Provides for certain exemptions in the care given children.

In regard to proposed amendments to Section 36-135 ARS, providing (a) salary of Commissioner of Public Health to be fixed by the Board of Health, subject to legislative appropriation; and (b) Commissioner shall hold a public health degree or be Board Certified in Preventive Medicine, it was the feeling that subordinate employees of the Health Department should not receive more than the Commissioner.

MEETING ADJOURNED FOR LUNCHEON AT 1:15 P.M.

* * * * * *

MEETING RECONVENED AT 2:35 P.M., ALL MEMBERS PRESENT DURING THE MORNING SESSION RESPONDING "AYE" TO THE ROLL CALL, ARTHUR R. NELSON, M.D., CHAIRMAN, PRESIDING.

COMMUNICATIONS

Anesthetists

The Arizona State Board of Nursing reports it is in process of reviewing possible revision of statute and its rules and regulations governing the practice of nursing. Of concern is Section 32-1661 ARS which deals with the administration of anesthetics by a registered nurse. It reads:

> "A licensed registered nurse may administer anesthetics under the direction of and in the immediate presence of a licensed physician or surgeon if the nurse has taken a prescribed course of anesthesia at a hospital in good standing, or is a graduate in the science of anesthesia from a recognized school or college."

That Board is interested in defining the scope of practice for the nurse anesthetist and establishing criteria for competency. Comments and/or suggestions are sought with reference to the phrase: "in the immediate presence of a physician or surgeon."

It was stated a similar request was made of the Board of Medical Examiners of the State of Arizona and it has authorized a response that the section should be continued as currently stipulated in the law to better protect the nurse anesthetist, the hospital and the doctor of medicine; there should be no change.

It was regularly moved and unanimously carried that it be the recommendation of this Legislative Committee to the Board of Directors of the Association that it be suggested to the Arizona State Board of Nursing that the phrase "under the direction of and in the immediate presence of a physician or surgeon" be changed to: "under the supervision of a licensed physician."

Other proposed changes in the Act dealing with licensing and regulation of nursing include: (a) simplifieation of Section 32-1631 relating to "Acts and Persons not Affected by Chapter;" and (b) clarification of "professional" vs. "registered" nurse.

Board of Health and Rehabilitation Service

It is reported by the Health Facilities Planning Council that Rep. Frank Kelley has instructed the Legislative Council to draft a bill which would create a State Board of Health and Rehabilitation Service to be comprised of five lay persons with particular interest in health and rehabilitation service. A brief review of some of the proposed provisions was outlined together with the submission of a proposed organization chart. RECEIVED.

Handicapped Children — Education

The Arizona Chapter of the American Academy of Pediatrics (Arizona Pediatric Society) seeks support for the enactment of legislation which would assist in the education of the handicapped child at the time when he can best profit thereby. It is understood the Arizona law forbids use of state funds in teaching children under six years of age. It is desirable that there be developed a program whereby funds would be made available for special educational purposes in the early years for handicapped children.

It was determined to correspond with Dr. Spendlove to ascertain whether or not, in his opinion, this subject would be an appropriate part of his program; and if so, whether he would be agreeable to sponsor such legislation with the knowledge that in principle, the Committee approves of the recommendation of the Arizona Pediatric Society.

Implied Consent — Blood-Alcohol Test

S.B. 19 was introduced in the Second Regular Session of the 28th Arizona State Legislature, January 10, 1968, providing when a person operating or in actual physical possession of a motor vehicle on a highway is deemed to have consented to a chemical test, etc. It failed of passage. It is reported that a similar law is being drafted by Walter Cheifetz, counsel for the Arizona Hospital Association. It is suggested protection be given the doctor, the hospital and anyone else when blood is drawn in any emergency room for routine purpose without consent when the patient is unconscious or intoxicated. Personal liberty is involved and how much one can do when the individual is unconscious and, has the doctor in fact committed a trespass if under certain conditions he takes tests without the consent of the patient. Determined to contact either Walter Cheifetz, counsel, or the Arizona Hospital Association, and ascertain the status of such legislation to be proposed.

MEETING ADJOURNED AT 3:30 P.M.

John P. Heileman, M.D.
Secretary

PUBLIC RELATIONS COMMITTEE

Meeting of the Public Relations Committee of The Arizona Medical Association, Inc., held in the Central Office, Suite 201, 4601 North Scottsdale Road, Scottsdale, Arizona, October 26, 1968, convened at 2:05 P.M., John F. Kahle, M.D., Chairman, presiding.

ROLL CALL

PRESENT: Drs. Kahle, John F., Chairman; McKinley, Jr., William W.; Mowrey, Jack I.; Scott, William C.

STAFF: Messrs. Carpenter, Robert, Executive Secretary; Robinson, Bruce E., Assistant Executive Secretary.

EXCUSED: Drs. Dudley, Jr., Arthur V., President; Eicher, Walter R.; Flynn, Richard O., President-Elect; Fredell, C. Herbert; Heileman, John P., Secretary; Langston, Don V.; Lyle, William H.; Reger, Jr., Harry L.; Schoen, Roland F.; Volk, Philip D.

MINUTES

Minutes of the meeting of the Public Relations Committee held October 29, 1967, were approved as distributed.

EXISTING PROGRAMS

Mr. Robinson gave a brief background and report on existing P.R. programs as follows:

a. A brochure explaining the new Arizona Medical Association Historical Collection is being prepared for early distribution to the membership.
b. A brochure dealing with the newly created Arizona Medical Association Foundation is being designed for distribution to ArMA members and other interested parties.
c. A brochure explaining the Comprehensive Health Planning law has gone to all members this year.
d. Thirty-eight educational films have been distributed so far this year to high schools and schools of nursing.
e. Since the beginning of 1968 over 59,000 health brochures have gone to 65 schools.
f. Nineteen requests for the Health Careers Filmstrip Kits have been fulfilled.
g. The Health Tips mailing list is currently at 2,510 and great continuing interest in this program is evident.
h. Eighteen hundred copies of **Horizons Unlimited** have been distributed during the first 10 months of 1968.
i. Medical Memos, the unscheduled newsletter, has averaged two issues a month this year, and still seems to be a most effective communication device.
j. A new brochure on our Medical Student Loan and Scholarship program has been created and distributed to all colleges in Arizona.
k. Following the direction of the committee at its last meeting, a copy of "Medicine in Territorial Arizona" has been placed in every high school library in the state.
l. The Physician Placement bulletin continues to grow. We receive 80 to 90 inquiries every six weeks from interested physicians.
m. The Title XIX Newsletter has been dormant during the past six months due to lack of activity.

Discussion was had on the "over budget" status of this committee. It was noted that the Executive Committee was apprised of this over budget situation, and chose not to cut back the activities of the committee.

1969 ANNUAL MEETING

Mr. Carpenter related the request of the Scientific Assembly Committee to the P.R. Committee to assist in the handling of P.R. during the 1969 annual meeting. Various suggestions were made as to how best to improve the P.R. for that meeting.

It was agreed that members of the Public Relations Committee would function as liaison between the news media and the guest speakers. Mr. Carpenter is to develop a schedule of interviews, etc., with the assistance of John S. Turner of John S. Turner Associates.

It was decided that a meeting of the committee should be held in late March 1969 to firm up plans.

OTHER BUSINESS

The Physician's Image

Discussion ensued on the general subject of how to improve the physician's image. Several recommendations were made.

1. When a physician leaves his community to attend scientific meetings, he should advise his local paper.
2. ArMA expand and up date its photographic and biographic files so that background material is readily available to the press when inquiries are made.
3. Every effort should be made to publicize the physician's activities in such groups as the Heart Association, service clubs and other philanthropic activities.

MEETING ADJOURNED 3:30 P.M.

John P. Heileman, M.D.
Secretary
By Bruce E. Robinson
Assistant Executive Secretary

MEDICAL ECONOMICS COMMITTEE

Meeting of the Medical Economics Committee of The Arizona Medical Association, Inc., held Sunday, October 27, 1968, in the Central Office of the Association, Suite 201, Safari Building, 4601 North Scottsdale Road, Scottsdale, Arizona, convened at 10:15 a.m., Arthur V. Dudley, Jr., M.D., President and Acting Chairman, presiding.

ROLL CALL

PRESENT: Drs. Armstrong, Richard S.; Crawford, Robert F.; Dudley, Jr., Arthur V., President and Acting Chairman; Dregseth, Kenneth A.; Heileman, John P., Secretary; Hoffman, George L.; Smith, Gregory C.

STAFF: Messrs. Carpenter, Robert, Executive Secretary; Robinson, Bruce E., Assistant Executive Secretary.

GUESTS: Messrs. Fisher, Charles, President — Armada Assurance Agency, Inc.; Orth, Boyd, Farmer-Orth Agency, Phoenix.

EXCUSED: Drs. Brown, Harvey G., Vice Chairman; Chesser, Ian M., Chairman; Flynn, Richard O., President-Elect; McDonald, Richard T.; McGregor, Jr., John G.; Melick, Dermont W.; Ricker, John H.

MINUTES

Minutes of the meeting of the Medical Economics Committee held June 30, 1968, approved.

FINANCES

Reported that out of a 1968 Budget of Appropriations of $700.00, a sum of $576.90 has been expended to and including September 30, 1968. RECEIVED.

CHAPTER 6, LAWS OF 1968 — WORKMAN'S COMPENSATION

In absence of the Chairman, Dr. Chesser, no report submitted as regards progress of negotiations with the

Industrial Commission of Arizona in the matter of adjustment of the existing fee schedule in line with the usual, customary and reasonable fee concept, as authorized by the Board of Directors, July 14, 1968. It is anticipated a report will issue by the next meeting of this Committee.

ICA PATIENTS — FREEDOM OF CHOICE — RULE NO. 59 (a)

Reviewed discussion and action of the Board of Directors in meeting held July 14, 1968, referable to the Tucson Clinic, and Rule No. 59(a) of the Industrial Commission of Arizona relating to "freedom of choice of physician," which reads:

> "(a) Every employee must submit to and follow the treatment and directions of the attending physician employed by his employer, or where the employer is insured for medical treatment by the employer's insurance carrier. An injured employee will not be permitted to voluntarily change from one hospital to another, or from one doctor to another, without the written authorization of the Commission."

The Board referred back to the Medical Economics Committee this problem, directing that it contact the Industrial Commission of Arizona, particularly Dr. Edwards, and discuss this whole matter to see what they can come up with.

ICA Case Report

Robert A. McCulley, M.D. (Phoenix) submitted for review the case of Charles M. Farnsworth, employee of Reynolds Aluminum, stating that a fundamental principle is involved, as regarding the practice of medicine and surgery, as it pertains to certain situations in the industrial or work-incurred injuries and illnesses in the State of Arizona.

Maricopa County — Safety Section

Presented for review was an 8½" x 11" card entitled: NOTICE TO EMPLOYEES setting forth Rules [including 59(a)] of the Arizona Industrial Commission relating to Industrial Accident Claims, prepared for "permanent posting" by the Safety Section of Maricopa County.

Rule 59(a) ICA

Report of Counsel to the Legislative Committee in meeting held October 20, 1968, referable to Rule 59(a) of the Industrial Commission of Arizona, concerning the use of the Tucson Clinic by certain industrial employers, highly summarizing the background of the law; comments of Robert K. Park, General Counsel — Administration of the Industrial Commission, at that meeting; and conclusion reached i.e. "that the Legislative Committee go on record favoring the administrative approach to a change in Rule 59(a)," was reviewed by Dr. Dudley for the edification of this Committee.

Richard K. Hausmann, M.D., President of The Tucson Clinic, by letter dated October 12, 1968, addressed to the Medical Economics Committee, relating to deliberations of this Committee published in the September, 1968, of Arizona Medicine stating that the Tucson Clinic has established "contractual arrangements" with several mining companies which it is felt are unethical, stated: "The stigma of unethical conduct is particularly repugnant to any physician and is categorically denied. The situation over which you express concern has been the subject of official consideration by the Arizona State Medical Association in the past without such consideration resulting in criticism of any individual or group." It then proceeded to review the law under which it operates, similar to that of other individuals and/or groups.

LAFB Case Report

Loy G. Roberts, M.D. (Glendale) submitted for review a case involving a civilian employee at Luke Air Force Base (a patient of his), likewise revealing a problem relating to "freedom of choice of physician."

Legislative Committee

In favoring "the administrative approach to a change in Rule 59(a)," it is the thought of the Legislative Committee that this Committee should contact ICA and endeavor to resolve the issue. If unsuccessful, then a legislative approach might be considered.

It was regularly moved and unanimously carried that the Medical Economics Committee pursue this matter on an administrative approach with the new Industrial Commission of Arizona, when it is selected; that the Board of Directors be so informed; and that this subject be retained as an active item on the agenda of this Committee.

FRANCHISE GROUP CANCER PLAN

Mr. Russell Glasser (Phoenix), General Agent, American Family Life Assurance Company of Columbus, Georgia, proposed for consideration an "Employee Franchise Group Cancer Plan." RECEIVED.

FULL-TIME SALARIED HOSPITAL PHYSICIAN EMPLOYEE SURVEY

Reference was made to the survey conducted by Arizona Blue Shield relating to full-time salaried hospital physician employees under the chairmanship of Dermont W. Melick, M.D., Blue Shield Board member. Dr. Melick advised a final report was made before the House of Delegates which concluded his efforts along these lines. He volunteer to continue as a member of that Committee (not as chairman); however, he had received no further instructions from Blue Shield and does not know whether the committee is still in existence.

It was regularly moved and unanimously carried that the matter be tabled.

OTHER BUSINESS

Professional Liability Insurance

Presented was considerable material relating to "professional liability insurance," and study by the Medical Review and Advisory Committee of the California Medical Association on the subject: "Should CMA Form a Physician Owned or Controlled Malpractice Carrier" concluding: "It is the inescapable and unalterable conclusion of this study that the formation of a physician owned or controlled malpractice insurance carrier by CMA would not be in the best interests of either the physicians or the public."

Armada-Farmer-Orth Agency Proposal

On invitation of the Chairman, Dr. Chesser, Mr. Charles Fisher, President of the Armada Assurance Agency, Inc., and Mr. Boyd Orth representing the Farmer-Orth Agency (both of Phoenix) were present and presented a proposal providing professional liability insurance for the membership of the Arizona Medical Association.

The insurance carrier would be The Hawaiian Insurance & Guaranty Company, Ltd. A financial statement as of December 31, 1967, showed Total Admitted Assets of $8,576,420.00; Total Liabilities of $5,346,499.00; and Total Capital and Surplus of $3,229,921.00.

MR. FISHER: Some two years ago we were given a Broker of Record letter and authorized to seek out a carrier who would give consideration to offering malpractice coverage to ArMA members on a quasi-group basis. Diligent effort and search up until recently proved rather fruitless.

We were able to put together a Million Dollar Umbrella on a blanket basis at attractive rates. These rates are now increased by class.

Within the past two years rates on primary coverage have been increased on two occasions. The most recent, October 2, nearly 90%. Two companies have withdrawn from Arizona. A third company has discontinued their three-year contract with discounted premiums the second and third years. They are now also reluctant to issue to specialists in Classes IV and V even at the currently increased rates, and they want all of your other business.

In pursuing our search we had drafted certain desirable specifications which included (1) careful and strict underwriting, (2) lower than manual premiums, (3) three-year contracts, (4) and most importantly, covered Arizona physicians to be rated in the future on their own claims experience as a group. In other words, we wanted to eliminate the inference that Arizona rates are suffering because of the proximity to known higher claims experiences. Even so, the physician who has had no claim or allegation is going to feel unjustly discriminated against if Arizona settlements cause future rate increases. And the doctor who is declined because of our underwriting standards is not going to feel very friendly towards us.

We now have a carrier. They have requested a 15% deviation from manual rates from the insurance department. We have asked for individual three-year contracts. And let me carefully explain this: our target date is December 1, using deviated current rates. Dr. A applies for and is issued a policy with a period of coverage from December 1, 1968, to December 1, 1971. Premium $1,000 per year. He will pay that premium for three years. On the other hand, Dr. A's existing policy expires October 1, 1969. He applies for our coverage effective that date. In the interim there has been a 10% rate increase to $1,100 for the same coverage. He will pay $1,100 each year for three years. However, should the entire program go sour, all rate structures must be revised as a group.

Let me also explain what 15% means. It doesn't sound so big to the solo Class I or II. However, to two Class V partners it's a discount of $568 per year. Two Class V partners at manual rates for 100/300 have a combined premium of $3,792. 15% in this area becomes really attractive.

Let's look to a bright side — and a side which we certainly hope comes to pass — Arizona claims experience indicates that current rates are in excess of those necessary to maintain a healthy loss ratio. Should this happy event take place we will ask that your rate be reduced on the next anniversary date.

When we first started negotiations with Hawaiian, they, of course, also wanted to restrict the Class IV's and V's and had some other obstacles for us to overcome. I'm happy to say that the only two restrictions we now have is experimental surgery and transplants.

They have asked for a good participation in Classes I and II. We agree that to create a healthy spread for everyone they should have it.

They have also indicated that future profitable collateral business from the program's insureds will serve to offset underwriting losses which might be sustained in the malpractice area.

If this committee approves the project and it is subsequently approved by the Board of Directors, we will have a kick-off date of December 1. We will need the resources of five forces to get the job done: The State Association, Pima and Maricopa County Societies, The Hawaiian Insurance Company, and the Armada Agency. Plus — we would like to request this committee or the executive offices to solicit the aid of Yuma, Coconino and Yavapai which represent some 80 members.

I have met with Dr. Charles Finney, insurance chairman of Maricopa, and he has indicated if his committee is satisfied with the financial strength of Hawaiian, he will recommend the program. We have asked Dr. Chesser to take the program to Doctors Wilson and Weber in Pima.

A strong and concerted effort is necessary for the success of the program. A successful program is necessary if we are to stand any chance of improving the malpractice situation for your membership.

Many doctors are insured with companies which are well known and strong companies and with which the doctor has been for many years. Other doctors have had to change carriers several times during the past few years because of companies leaving the field. We realize there will be some reluctance to our offer and certainly a great many questions concerning the carrier.

Mr. Boyd Orth of the Farmer-Orth Agency, representative of the Hawaiian Insurance Company in the State of Arizona, who has worked diligently in helping us put this program together for you, will give you some history and facts on the carrier.

Considerable discussion ensued. Both Mr. Fisher and Mr. Orth submitted to questions.

It was regularly moved and unanimously carried that Dr. Chesser be appointed as an Ad Hoc Committee of one to develop specifications for underwriting the Hawaiian Insurance & Guaranty Company, Ltd., plan.

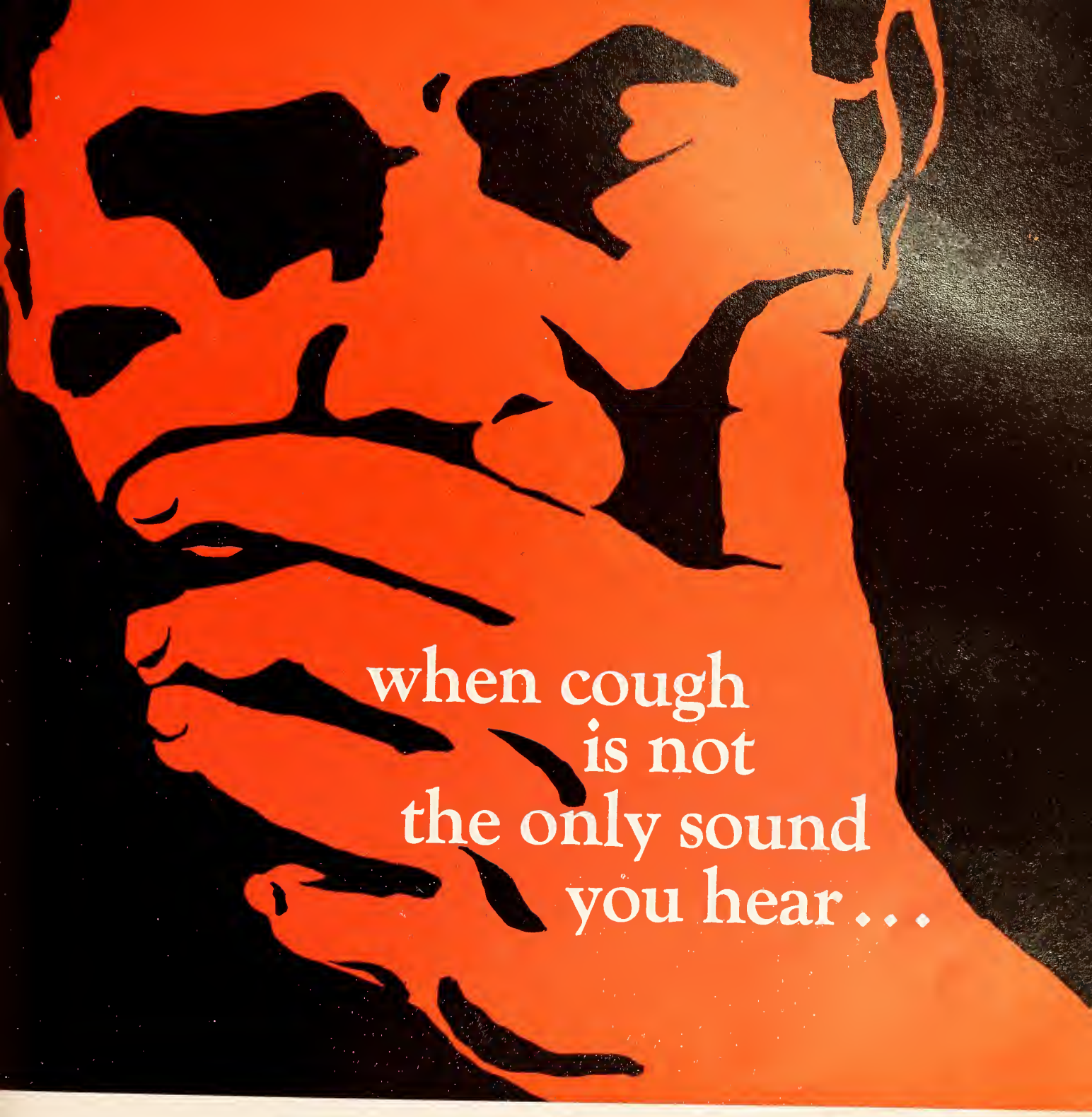
It was regularly moved and unanimously carried that the Medical Economics Committee recommend to the Board of Directors that, contingent upon investigation of the Hawaiian Insurance & Guaranty Company, Ltd., and such other personal investigations that might be indicated, this professional liability and insurance plan, as presented, be made available to the membership.

Meeting — 12/29/1968

It was observed, the next regularly scheduled meeting will be Sunday, December 29, 1968. Because of the closeness to the New Year holiday, it was recommended that this meeting be cancelled and held at a later date.

MEETING ADJOURNED AT 12:45 P.M.

John P. Heileman, M.D.
Secretary



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. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

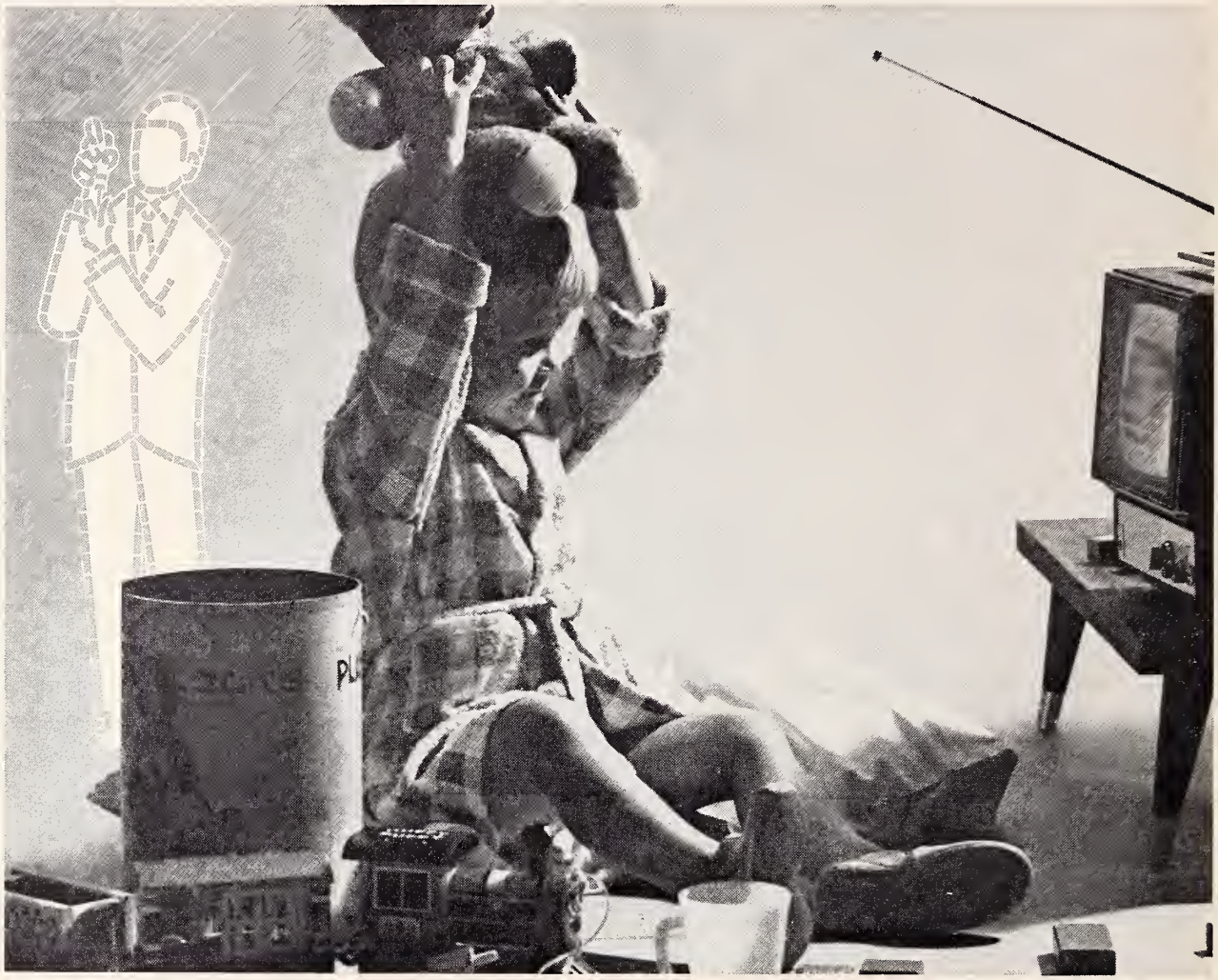
Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

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It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

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Additional information available to physicians upon request.

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EVALUATION OF CONSERVATIVE ORTHOPEDIC MANAGEMENT OF COMMON VARIETIES OF KNOCK-KNEES, BOWLEGS, AND TIBIAL TORSION

David W. Florence, M.D.
John R. Schwartzmann, M.D.

A timely article on some of the more commonly encountered orthopedic conditions in children is presented. The illustrations themselves give great impact to the review, while the article itself is filled with information.

In the average day-to-day practice of orthopedics, one of the more commonly encountered conditions in children embraces mild degrees of knock-knee, bowlegs and both internal and external torsion of the tibia. Accepted forms of treatment range between the philosophy of "do nothing" and judicious neglect, to the extremes of expensive bracing, long term casting, and in some instances surgical treatment such as osteotomy and epiphyseal stapling.

Although there is no strict control in the series being reported, it is the strong feeling that a great number of the above conditions would probably correct themselves if nothing is done through a few years of growth and functional adaptation. However, it is also known that a number of the knock-knee, bowleg and torsional deformities do not correct on a program of no directed treatment.

Because many of the children with these deformities have, in the authors' experience, prominence of the parietal and frontal bones as well as flaring of the rib cage, palpably prominent costochondral joints and palpably prominent epiphyseal lines of the long bones of the lower limbs; the concept is strongly suggested that these conditions are frequently related to, or the result of, a mild degree of active rickets and need attention along lines of useful simple therapy. (Figs. 1A, 1B, 1C, 1D, 1E)

Eighty-seven consecutive cases in a crippled children's clinic service are hereby analyzed and the results of the applied therapy are reported.

It is well known that the ability to utilize ingested vitamin D is dependent upon the individual's ability to metabolize it. Variations in dosage requirements to prevent or control rickets vary within members of the same family. High dosage of vitamin D has been the primary therapeutic measure offered in the analyzed cases.

Of the 87 patients studied (Table I), 12 had some degree of rickets evidenced either by clinical, X-ray or laboratory findings confirming such diagnosis as well as the history of having failed to receive adequate vitamin D intake prior to the time first seen. Seven cases showed simple internal torsion of the tibia as a primary problem. Forty-two (Figs. 2A, 2B, 2C, 3A, 3B, 4A, 4B, 4C, 5A, 5B, 5C, 5D) showed genu varum, and 26 genu valgum, as the admitting complaints bringing them to the crippled children's clinic. Fifty-nine of the 87 patients showed some foot imbalance; either a relaxed flatfoot, congenital flatfoot, pronated hindfoot, valgus or varus foot problems; along with the lower limb abnormalities for which they were initially examined (Figs. 6A, 6B, 7A, 7B).

TABLE I
Primary Diagnosis in 87 Patients Reviewed

Rickets	12
Internal torsion of tibia	7
Genu Varum	42
Genu Valgum	26
Total	87



Fig. 1A — Patient S. B. Asymmetric bowleg — internal torsion, bilateral. Before treatment.



Fig. 1B — X-ray of patient S. B. before treatment.



Fig. 1C — Patient S. B. one year after beginning treatment.

The foot problems as presenting were treated independently of the leg deformities by the use of proper shoes and shoe lifts.

Eighty-three per cent of the patients studied had been on a daily vitamin D supplement, quantatively acceptable as a daily requirement by pediatric standards, and in spite of this developed progressively, or failed to correct deformities that were present. Seventeen per cent had no vitamin D at the time first seen.

All children reported in this series were under 5 years of age at the time first seen. The average at the beginning of treatment was 24 months, the youngest patient being 5 months of age, the oldest being 5 years of age at the onset of therapy. It is the authors' opinion from experience that in children over 6 years of age, unless frankly deficient in dietary and vitamin intake that supplemental vitamin D has little effect on the dietary balance.

Those patients classified primarily as genu varum or genu valgum (Table II) also showed other deformities in addition to the knock-knee or bowleg. Internal torsion of the tibia was present in 55 cases, pes planus in 17 cases and external torsion of the tibia in three cases. In only two of the patients reported was the limb deformity unilateral; all others bilateral.

TABLE II
Incidence of Associated Deformities in Primary Diagnosis of Genu Varum or Genu Valgum

Internal torsion of tibia	55 cases
Pes planus	17 cases
External torsion of tibia	3 cases

Treatment in this series embraced no casting or braces and eliminated the use of Dennis Brown splints and similar equipment. Proper shoes for the management of the foot problems when present were used along with adequate dietary intake of milk or milk substitutes and vitamin D. A standard concentrate of natural fish liver oil products was used and a daily dosage of 20 to 40 drops of such concentrate was given depending upon the age of the child and the severity of the condition. In addition to this the early management was supplemented by the use of high potency vitamin D. In this instance Infron capsules were selected for use supplementing the intake of fish liver oil concentrate. These capsules contain 100,000 units of vitamin D, manufactured by Whittier Laboratories of Evanston, Illinois. In infants the contents of the capsule would be emptied into milk or mixed with jelly or syrup for ingestion. Older children take the capsule whole. There were administered, 1 capsule weekly for six weeks, then 1 capsule every two weeks usually for 10 to 12 months, and one monthly for an additional 12 months if required. In many instances Infron supplement was discontinued before the end of the first year, and the continuation of the high dosage vitamin D was dependent entirely upon the de-



Fig. 1D — Patient S. B. 4½ years after beginning treatment. Mild knock-knee and external torsion.

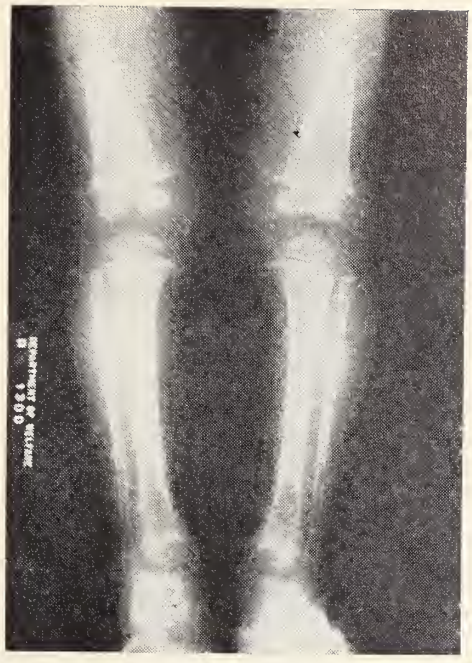


Fig. 1E — X-ray of patient S. B. after treatment.



Fig. 2A — Patient C. VW. Internal torsion. Before treatment.

gree of correction or failure of correction in a given observation period. The daily vitamin D intake of fish liver oil concentrate was carried through the end of the 5th year in each child, and each 20 drops of the concentrate contained approximately 4,000 units of vitamin D.

The average total length of Infron therapy was 18 months; the shortest period being four months, the longest 41 months. The average length of total therapy; that is, daily vitamin D supplement in addition to the Infron was 2½ years; the shortest period being six months, the longest period of combined treatment nine years. This latter case was continued past the fifth year only because of misunderstanding and language difficulty with the parents, and seeing the child some four years between visits. It was found that the daily vitamin D as well as the Infron on a monthly dosage basis had been continued over the four years. No difficulty was encountered and no complications from the prolonged use of the medication was noted to examination.

One of the reported cases had been on long leg braces for a period of two years when first seen in the clinic by the authors and had failed to correct bowlegs in braces up to that time. On the vitamin program the deformities corrected over the next 18 months without the use of braces. Dennis Brown type splints were not used in this series, but in a review of some 28 cases in which they were used on other services in the same area, it was noted that these splints are used less than 25% of the prescribed time, and their effectiveness in correction of torsional deformities was of no value statistically.

In seven patients in this series the change from initial genu varum to ultimate genu valgum was observed (Figs. 8A, 8B, 8C, 8D, 8E); four of these patients being on Infron; three of them had not been on Infron. The ultimate change to knock-knee was mild requiring no additional treatment.

Of 32 cases treated with Infron plus vitamin D concentrate daily, plus orthopedic measures as corrective shoes, lifts and wedges, the average length of time in therapy was two years and eight months. Of 13 cases treated with Infron plus vitamin D concentrate, without corrective shoes of any nature, the average duration of treatment was two years and five months. It is felt then that there is little or no related, or additional, benefit to the correction of these deformities by the use of shoes and wedges.

A purely controlled group for comparison to the reported cases is not available; however, in reviewing the problems of knock-knees and bowlegs in children over 6 years of age, who had had no treatment, seven cases were seen in the clinic for the primary complaint of knock-knee, bowleg or torsion, and it is evident that certainly not all cases correct spontaneously by



Fig. 2B — X-ray of patient C. VW. before treatment.



Fig. 2C — Patient C. VW. fourteen months later.



Fig. 3A — Patient M. G. Severe knock-knee. Before treatment.

growth alone.

Results

The deformities in all 87 patients corrected satisfactorily. No additional treatment beyond that described above was necessary. (Figs. 9A, 9B, 9C, 9D, 9E, 9F, 10A, 10B, 11A, 11B, 11C, 11D, 12A, 12B, 12C, 13A, 13B, 14A, 14B)

Discussion

It is the authors' opinion that the casual philosophy that rickets can be controlled in areas of abundant sunshine, and in children with reasonably adequate dietary intakes and an accepted average daily intake of vitamin D supplement is erroneous. When one is confronted with the problem of knock-knee, bowlegs or torsion in infants and small children under 5 or 6 years of age, the evaluation and therapeutic plan should consider the individual variations in the ability to utilize vitamin D in daily dietary intake and a supplement for obvious or suspected deficiencies in a useful procedure. There is no attempt in this paper to imply that the authors are presenting the ultimate in useful therapy for the simple knock-knee, bowleg and torsional deformities being discussed. In this series, of course, the chondrodystrophies, epiphyseal abnormalities and growth disturbances from trauma, disease, etc. are not included, and treatment for that particular group of conditions is defined according to the diagnosis.

It is, however, interesting that 16 patients in this particular crippled children's clinic can be treated through to completion on the proposed regime of vitamin D supplement for approximately the same price as can one child be fitted for one pair of braces in managing the same condition. Economically this is a factor. Considerable expense in crippled children's services is directed towards the use of the Dennis Brown type of equipment which, again, if used 25% of the recommended time is ineffective therapy with increased expense. The harassment of both child and parents of being tied to braces and such mechanical equipment over a long period of time is a factor to be seriously considered, and if time is not significantly shortened, and if results are not far superior to simpler means, then simpler and more benign therapy is indicated.

Conclusions

It is the conclusion of the authors that quite possibly the major portion of the reported cases would have corrected completely had no treatment been offered. In this series there was no failure of adequate correction of the deformities and further treatment beyond the program outlined was not required. It is further the opinion that the milder and common everyday variety of bowleg, knock-knee and torsional deformities in infants and small children is related to vitamin D metabolism and well may be considered a mild form of rickets, for therapeutic purposes.

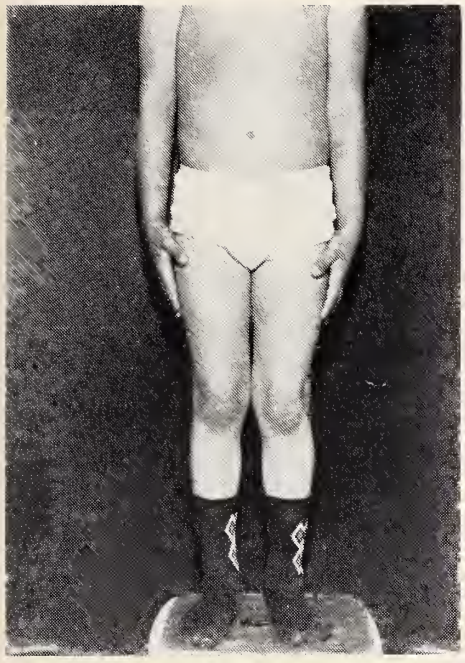


Fig. 3B — Patient M. G. Three years later.

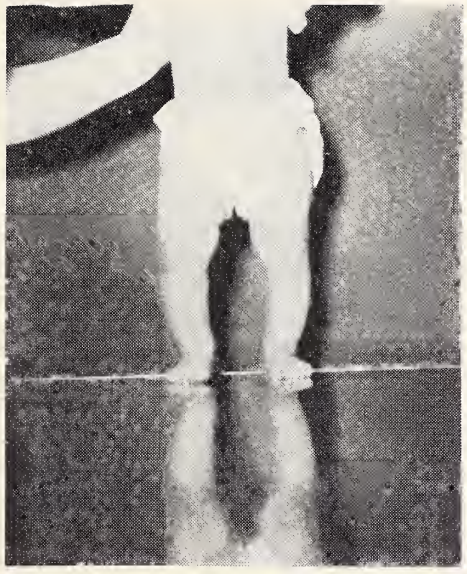


Fig. 4A — Patient B. M. Mild bowleg and internal torsion. Before treatment.



Fig. 4B — X-ray of patient B. M. before treatment.

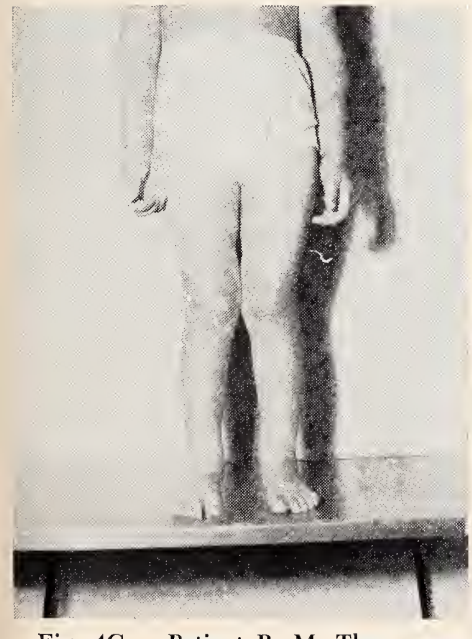


Fig. 4C — Patient B. M. Three years later.

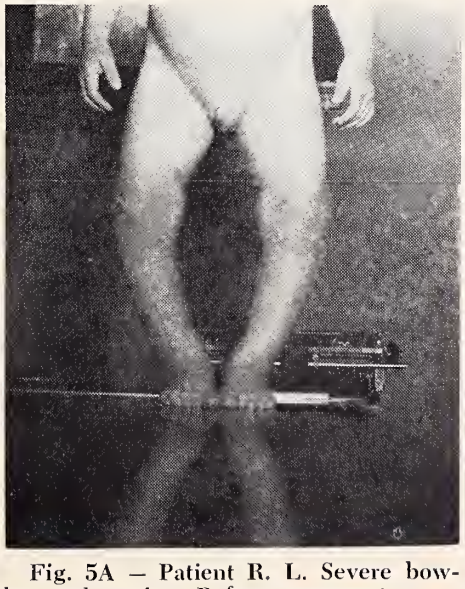


Fig. 5A — Patient R. L. Severe bowleg and torsion. Before treatment.



Fig. 5B — X-ray of patient R. L. before treatment.



Fig. 5C — Patient R. L. 3½ years later.



Fig. 5D — X-ray of pateint R. L. after treatment.



Fig. 6A — Patient E. P. Knock-knee, internal torsion. Before treatment.

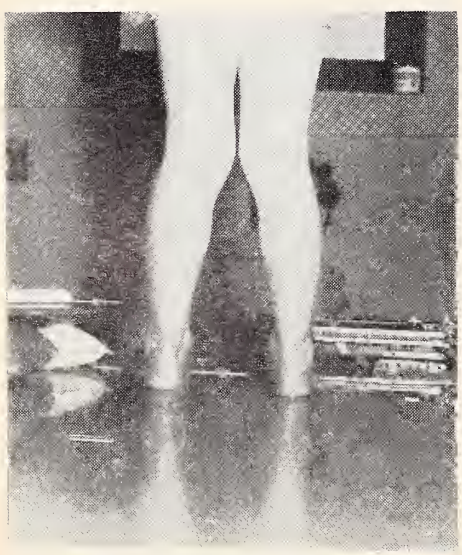


Fig. 6B — Patient E. P. Before treatment, normal hindfoot.

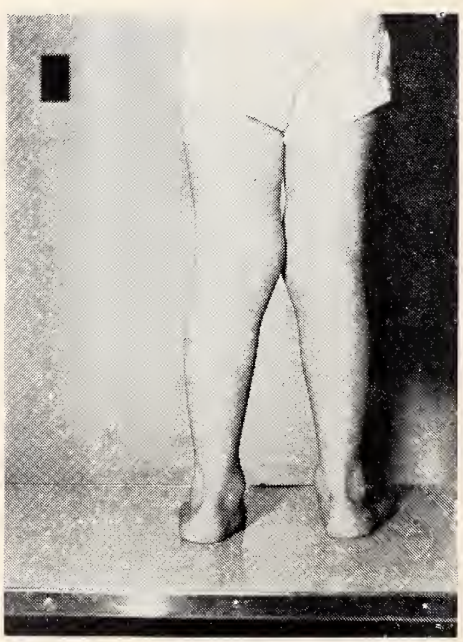


Fig. 7A — Patient D. D. Pronated hindfoot, knock-knee.

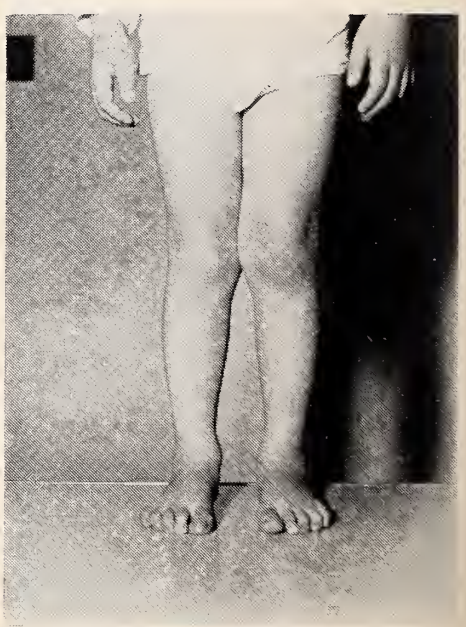


Fig. 7B — Patient D. D.



Fig. 8A — Patient C. C. Bowleg, internal torsion. Before beginning treatment.



Fig. 8B — X-ray of patient C. C. before treatment.



Fig. 8C — Patient C. C. 21 months after treatment started.



Fig. 8D — Patient C. C. 3½ years after treatment started.

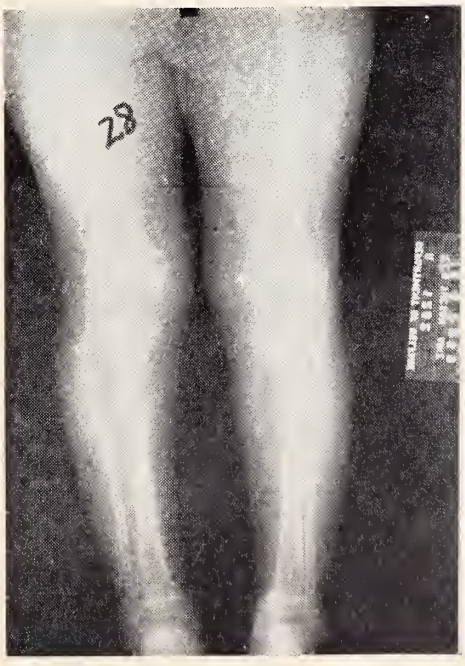


Fig. 8E — X-ray of patient C. C. after treatment.



Fig. 9A — Patient B. F. Bilateral varus and torsion, asymmetrie. Before treatment.



Fig. 9B — Patient B. F. before treatment.



Fig. 9C — X-ray of patient B. F. before treatment.

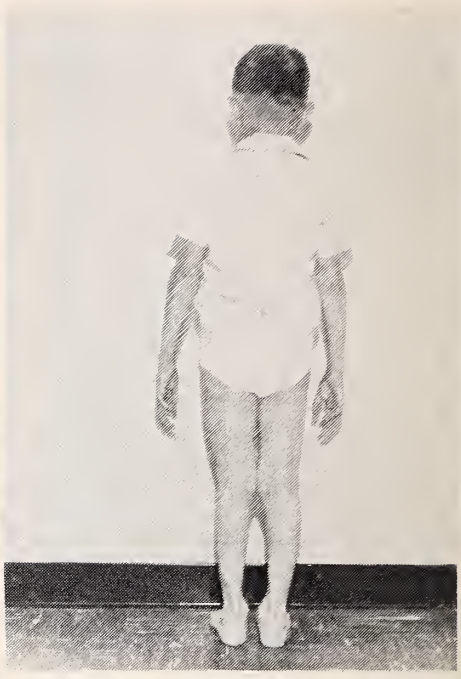


Fig. 9D — Patient B. F. 4½ years later.



Fig. 9E — Patient B. F. 4½ years later.

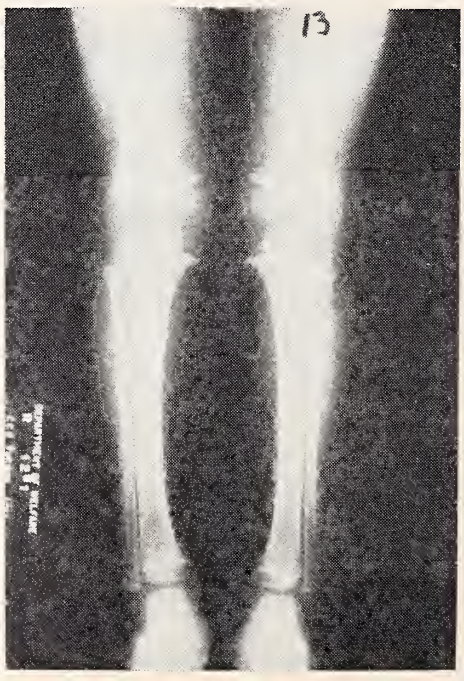


Fig. 9F — X-ray of patient B. F. after treatment.



Fig. 10A — Patient D. G. Mild bilateral knock-knee and torsion. Before treatment.



Fig. 10B — Patient D. G. Six years later.



Fig. 11A — Patient A. F. Bowleg, internal torsion. Before treatment.



Fig. 11B — X-ray of patient A. F. before treatment.



Fig. 11C — Patient A. F. 14 months later.



Fig. 11D — Patient A. F. 18 months after treatment started.



Fig. 12A — Patient G. O. Bowleg, internal torsion. Before treatment.



Fig. 12B — Patient G. O. Correcting, six months later.



Fig. 12C — Patient G. O. 18 months later.



Fig. 13A — Patient J. M. Severe knock-knee and Pes Planus. Before treatment.



Fig. 13B — Patient J. M. 3½ years later.



Fig. 14A — Patient P. M. Mild bowleg and internal torsion. Before treatment.

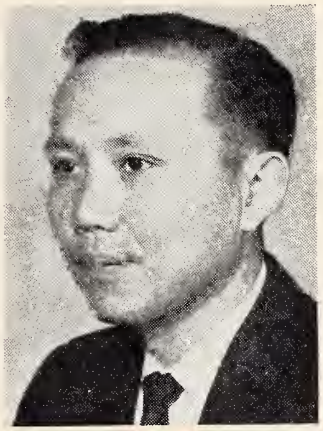


Fig. 14B — Patient P. M. nine months later.

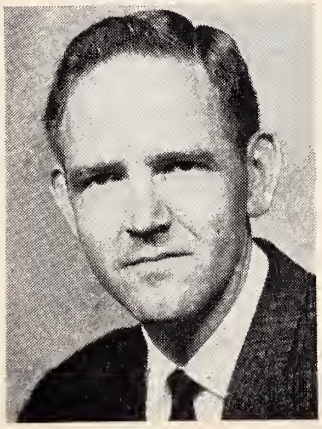
LIVER SCANNING

THE IMPORTANCE OF ROUTINE USE OF MULTIPLE PROJECTIONS

DEPARTMENT OF NUCLEAR MEDICINE
GOOD SAMARITAN HOSPITAL
1033 E. McDOWELL
PHOENIX, ARIZONA



John W. Wu, M.D.



Robert H. Thoeny, M.D.

Comprehensive studies have determined the value of the liver photoscan. It provides a more accurate method of diagnosing space-occupying hepatic lesions than any other single liver function test. The over-all accuracy of liver scanning has been reported in some series as 77% and by other observers to be in the vicinity of 92%. In contrast to this, needle biopsy of the liver yields an accuracy of only about 65%.

Because of the anatomy of the liver, it is generally conceded that small lesions located along the margin or deep within the liver substance may fail to be detected by scan. A lesion in the right lobe, particularly deep within the thickest part of this organ, must be at least 3 cm. in diameter before it can be visualized. If such a lesion is situated in the posterior right lobe adjacent to the border, it may not visualize on a single anterior scan. With the mass of tissue overlying this area even posterior projections may not show the lesion clearly and it may only be visualized adequately by means of a right lateral view where the lesion is seen tangentially. Therefore, multiple projections should be used routinely including anterior, posterior, and right lateral scans. The following case fully illustrates this point.

Case Report

A 34-year-old white female had surgical excision of a salivary gland cylindroma in 1954. Approximately 10 years later a mass was noted in the left lung on chest x-ray which on biopsy proved to be metastatic cylindroma. She subsequently developed metastatic disease within the peritoneal cavity and in October 1967 an explora-



Fig. A — Au-198 Rectilinear scan. Normal appearance. Time of study — 40 minutes approx.

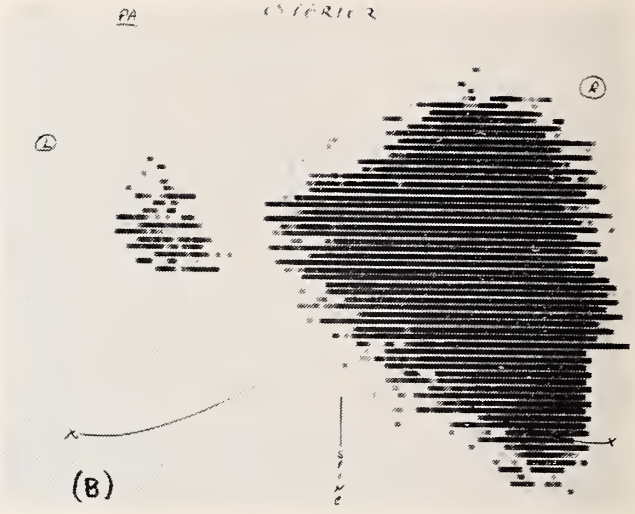


Fig. B — Rectilinear scan. Posterior view. Normal appearance. Time of study — 45 minutes approx.

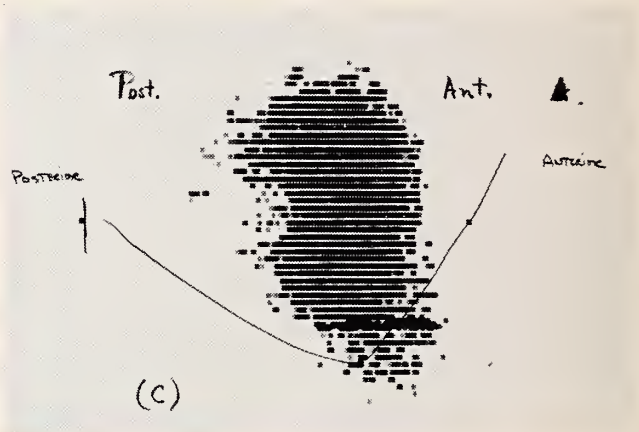


Fig. C — Rectilinear scan. Right lateral view. 3cm. nodule on posterior surface or right lobe. Time — 35 minutes.

tory laparotomy revealed a palpable nodule in the posterior liver surface consistent with metastasis. A liver scan with 198 Au colloid was done using a rectilinear 3-inch scanner which failed to demonstrate a lesion in either anterior (Fig. A) or posterior (Fig. B) projections. The right lateral scan (Fig. C), however, showed a definite 3-4 cm. lesion situated on the posterior surface of the right lobe. The study was repeated several months later, using 198 Au colloid but on an Anger Camera (Fig. D-F). The lesion was again well visualized in the right lateral projection (Fig. F) but not in the anterior (Fig. D). The posterior scintiphoto study (Fig. E) on the Anger Camera did demonstrate the lesion but with much less clarity than on the lateral view. Incidentally, the patient's lesions and symptoms have been satisfactorily controlled to date by means of a combination of radiation therapy and 5-fluorauracil.

Comment

Many nuclear medicine facilities are limited to 3-inch rectilinear scanners. When the radiopharmaceuticals available include only 198 Au colloid, 131 I rose bengal and 131 I micro-aggregated albumin the objection to the time consumed in obtaining three views is well taken. In the case illustrated, the first study was done with a 3-inch Baird Atomic rectilinear scanner and each view took 30-45 minutes to obtain. With the advent of rapid imaging devices such as large crystal rectilinear scanners and scintillation cameras the problem of long image build-up time has been obviated.

The second study illustrated using a similar dose of 198 Au but done on the Anger Camera took only 6 minutes per view.

Technetium-99m sulfur colloid is now the



Fig. D — Au-198 Anger Camera Scintiphoto. Anterior view. Normal appearance. Time of study — 6 minutes approx.



Fig. F — Anger Camera Scintiphoto. Right lateral view. 3cm. nodular lesion posterior surface of right lobe. Time of study — 6 minutes approx.



Fig. E — Anger Camera Scintiphoto. Posterior view. 3cm. nodule posterior right lobe with possibly smaller lesion next to it. Time of study — 6 minutes approx.

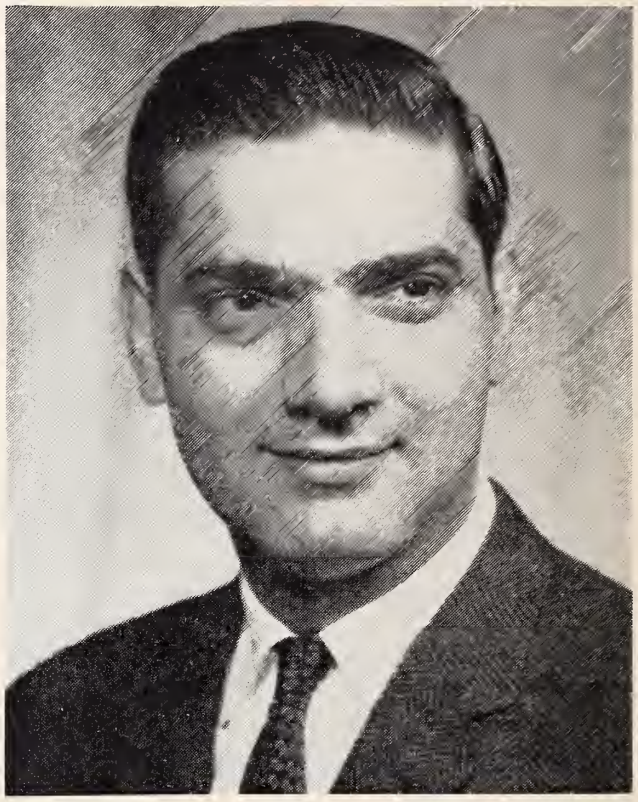
agent of choice for liver scanning and has recently become commercially available. It is hoped that this State Atomic Energy Commission will soon follow others in licensing this radiopharmaceutical for routine use. With 99m Tc sulfur colloid less radiation dose is delivered to the patient and the greater photon flux available makes it possible to use larger doses to obtain images of higher resolution in greatly reduced time and less patient discomfort. The use of this agent in conjunction with rapid imaging devices makes it possible to obtain multiple projections routinely thereby enhancing the accuracy of the examination. With 99m Tc sulfur colloid using a 1-3 millicurie dose a single view on the Anger Camera can be obtained in less than 30 seconds.

Summary

The routine use of multiple projections for liver scanning considerably increases the accuracy of the examination. This point is illustrated by a case report in which a space-occupying lesion located in the right lobe posteriorly was clearly seen only in the right lateral views. The problem of excessive time required to obtain multiple projections can be largely eliminated by the use of a rapid large crystal scanner or scintillation camera device. A plea is made for the acceptance of technetium-99m sulfur colloid as the current radiopharmaceutical agent of choice for routine liver scanning.

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Vincent A. Fulginiti, M.D.

Department of Pediatrics

Dean's Page

Faculty recruitment for the new College of Medicine has reached the stage where we must direct our attention to the development of clinical departments. Up to this point, expediency required us to organize our departments in a sequence that met curriculum needs.

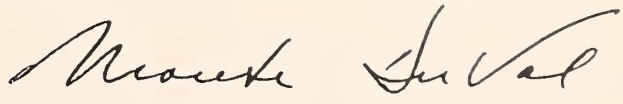
Internal Medicine came first. Beyond the obvious fact that this is ordinarily the largest and most important department in a medical school, it seemed wise to have an internist join the planning team early in order to benefit from his ideas relative to the architectural design of the Clinical Sciences wing and teaching Hospital. Next, about one year ago, we chose to develop our Department of Community Medicine, with two reasons in mind. First, the primary focus of its activities will be in an off-campus setting and the Head of that Department would need time to prepare his programs. Second, since much of the emphasis in undergraduate medical education is shifting to the ambulatory patient and to the family setting, we wanted very much to bring that influence into the curriculum as early as feasible. Then we could take the next step and develop Departments of Pediatrics, Surgery, Psychiatry, and Obstetrics and Gynecology.

We began to recruit for Pediatrics last winter. This proved to be an interesting experience because the field of Pediatrics is undergoing some profound changes. Antibiotics, improved immunologic capabilities, and better preventive care have had a marked effect on the practice of Pediatrics. Indeed, some consider the change as nothing less than startling in view of the shift in the distribution of patient care services as between in-hospital and ambulatory. Nationally (we have certainly seen this in Tucson), inpatient census on Pediatric services has fallen precipitously, while outpatient case loads have increased markedly. Well-laid plans for the development of children's services have resulted in the creation of hospital space that is now empty, in many instances.

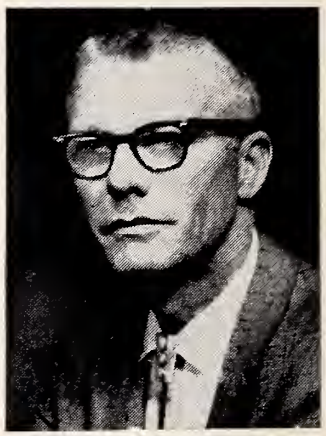
In view of these and other factors, we sought a Head for the Department of Pediatrics who would guide it in a manner consistent with the changes now taking place. We believe we have located precisely the right man for that assignment.

Vincent A. Fulginiti was born in Philadelphia in 1931. He received his Baccalaureate Degree from Temple University in 1953; his M.D. Degree in 1957 and a Master's Degree in 1961 from the same University. He undertook an internship at the Philadelphia General Hospital and a Pediatric Residency at St. Christopher's Hospital in Philadelphia, after which he was attracted to the University of Colorado for a Fellowship in Pediatric Infectious Diseases. Upon completion of his Fellowship, Dr. Fulginiti began a distinguished academic career at the University of Colorado, rising from the rank of Instructor to Associate Professor of Pediatrics. In addition to his service on many of his School's working committees, he is a Consultant to Fitzsimons General Hospital, Children's Hospital, General Rose Hospital, Denver General Hospital and the National Jewish Hospital — all in Denver. He is also a member of the Advisory Council for Operation Head Start in Denver, and a Consultant to the Colorado Immunization Committee of the Colorado Medical Society. He is certified by the American Board of Pediatrics and is a Fellow of the American Academy of Pediatrics, a member of the American Society of Microbiology, the American Academy of Pediatrics and the Society for Pediatric Research.

Dr. Fulginiti is a member of Alpha Omega Alpha, National Medical Honorary Society. He received first prize in pediatric research from the Philadelphia Pediatric Society, as well as the Ross Research Award from the Western Society for Pediatric Research. Dr. Fulginiti is a Markle Scholar in academic medicine and recently served as a Consultant to the Smallpox Research Laboratory in Madras, India, for the World Health Organization. He is married and has four children. The entire family will arrive in Tucson within the next few weeks. We are confident that all of the members of the Arizona Medical Association will enjoy having him here with us.



President's Page



ARTHUR V. DUDLEY, JR., M.D.
PRESIDENT

SEASON'S GREETINGS

As ArMA began the New Year on January 1, 1968, it was faced with a multitude of problems. Some of these have been solved or resolved with the passage of time. Others remain for possible solution in the coming months or years — and new problems for your Association are still in the period of gestation.

On Monday morning we are all good quarterbacks. ArMa's biggest failure this year was in the field of communication. Sincere efforts are being made to correct this fault. Special reference is made to the building program and assessment. A few of our members are so incensed that they are making efforts to divide organized medicine in Arizona. At the national level membership in the AMA has dropped for the first time in history.

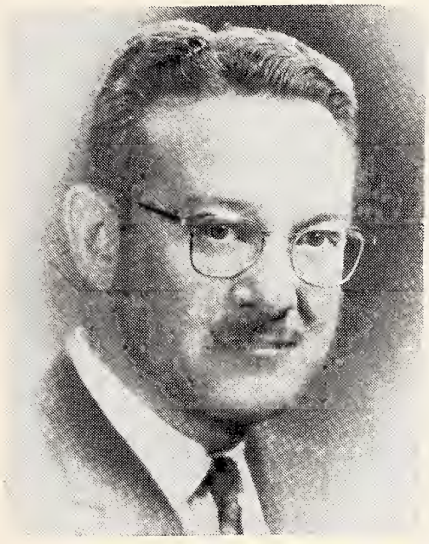
I'll be the first to admit that I do not agree with all the policy decisions made in Chicago or Washington by the AMA. This also applies to certain decisions made at the state or county level; however, whether I disagree or not, I will abide by the wish of the majority and the wisdom of organized medicine's leadership. At a time when medicine needs a stronger voice I would hope that each of us would work for a stronger representative organization rather than attempting to split, hence weaken, organized medicine.

As the Christmas Season approaches may I personally, and on behalf of the staff of ArMA, wish each of you a Very Merry Christmas and a Happy New Year. May we all start 1969 with past differences forgotten and work toward our singular goal — better medical care for our patients.

Arthur V. Dudley, Jr., M.D.
President

Editorial

DON'T SUE: ARBITRATE



Jack E. Brooks, M.D.

Disputes are insidious. They can occur anytime or anywhere and often when you expect them least. They occasionally find their way into the doctor's office.

Controversies involving payment of bills, malpractice, partnership business, the purchasing of supplies and equipment, leases, office construction and personnel employment are only a few of the issues faced by medical men.

Fortunately, most such disputes are resolved before they reach serious proportions. But the few that elude peaceful settlement can mean lawsuits and all the headaches modern litigation poses.

The answer to the litigation dilemma for an increasing number of medical practitioners is voluntary arbitration. Taken as indicated, it provides a highly effective alternative to court.

In its simplest form, arbitration is the determination of a dispute by an impartial third party appointed jointly by the parties. In effect, an arbitrator is the agent of both parties. He is empowered by them to render what amounts to a binding contract of settlement.

Arbitration proceedings are administered throughout the nation by the non-profit American Arbitration Association. A dispute filed in one of the twenty-three regional offices of the Association involved a physician and his young partner. They had practiced jointly under a verbal understanding for two years, with the younger doctor drawing approximately 30 per cent of the income from the practice.

Beginning the third year, the young physician began insisting upon an equal share of the profits. The elder doctor consented, but on the condition that the arrangement be considered temporary. When there was an opportunity to accurately determine each man's contribution to the practice, a permanent revision of the profit sharing was to be made; at least that was the older man's understanding.

Soon after the younger doctor's draw was increased, he became ill and was unable to practice regularly for more than a year. When he recovered, he decided to leave the partnership and demanded a salary settlement based on the 50-50 ratio. His partner refused, arguing that he was entitled to only 30 per cent of the income.

After weeks of quarreling, they finally decided to submit the matter to arbitration. They referred the dispute to the American Arbitration Association's (AAA's) Philadelphia Regional Office. They chose an official of the state medical society, who was a member of AAA's National Panel of Arbitrators as arbitrator and soon after appeared for a hearing at AAA.

The arbitrator heard their arguments behind closed doors and handed down a final and binding ruling days later. He found that the younger physician had at no time taken equal responsibility for the medical office and that he had contributed an average of about 32 per cent of the practice's income. He ruled, therefore, that 30 per cent was a fair draw and ordered a settlement on that basis.

Of course the matter might have been determined in a court of law, as often such disputes

are. However, by arbitrating the parties gained several advantages.

Firstly, by arbitrating they saved time. Because of backlogs in most courts, litigants find delays running into years just to bring their case to trial. Beyond that, are often further delays in appellate proceedings. By contrast, arbitration is generally completed within a few months and the award is final and binding. Often, AAA is able to administer urgent matters in even shorter periods.

Besides saving time, the parties minimized their expenses. In arbitration, the cost of administering the case, depends on the amount of the claims. In disputes with claims totaling $10,000 or less, AAA's rate is 3 per cent. Lower rates are applied to larger claims. Because arbitration doesn't take as long and it is easier for attorneys to prepare for an arbitration hearing, the parties also found their lawyer's bill substantially lower.

When a doctor's competence or integrity is questioned in a public courtroom, win or lose the case, the doctor's professional image is likely to become tarnished. Arbitration, being private, eliminates this worry. All AAA proceedings are held in strict confidence.

Another very important advantage of arbitration is that disputes are decided by persons who are familiar with the type of business at hand. Arbitrators, unlike judges, come to hearings with years of experience in the profession or trade. Doctors, attorneys, manufacturers and suppliers of medicines and equipment are only a few of the trades represented on AAA's 23,000 member National Panel of Arbitrators. This expertise of arbitrators, combined with their greater leeway than judges, often makes possible a more practical resolution of disputes than courts are capable of.

Thus, arbitration not only helps protect reputations, but also affords a system of swift, practical and economical justice.

Ironically, arbitration has been used to resolve commercial matters for centuries. Nevertheless, in modern times, it is best known in its recent industrial context. Most people tend to associate arbitration with picket lines, feuding employers and labor unions and the like. Still, commercial arbitration is used very widely in the commercial community.

One reason is that state and federal laws encourage its use. Toward this end, all states and the federal government empower courts to enforce duly rendered arbitration awards. Laws also guarantee those who arbitrate that the proceeding will be full and fair.

In line with the requirements of law, AAA has established rules and procedures which assure the parties the right to appear before an Arbitrator of their own choosing and to present all pertinent evidence at the Hearing.

A recent dispute illustrates how AAA operates.

The parties were a Los Angeles health plan and a medical group that had contracted to provide general and specialist services to members. Relations were satisfactory until officials of the health plan refused to pay a $2,000 bill for "super-specialist" services. Repeated attempts to collect proved futile, so the medical group decided to bring the matter to arbitration. Referral was prompt because of a clause in the contract that stated:

> Any controversy or claim arising out of or relating to this contract or the breach thereof shall be settled by arbitration in accordance with the rules of the American Arbitration Association and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

To set proceedings in motion, the medical group filed its demand for arbitration at AAA's Los Angeles Regional Office. On the form, the dispute was described briefly.

"The health plan has wrongfully withheld payment in the amount of $2,000," the statement read. "We seek a determination that services performed were in accordance with the contract and that payment in full is required."

AAA immediately forwarded a copy of the demand to the health plan advising its officials to file an answering statement within seven days. The answer was that the contract required the medical group to obtain the health plan's medical board's authorization for all "super-specialist" services. The chest-surgery performed fit into that category, but the medical group had not asked for or received authorization. Therefore, it was argued, no payment was required.

This information enabled AAA's staff to compile a list of arbitrators from the National Panel of Arbitrators who were suitable for the case. The list included medical men and attorneys. Each side received a copy of the list with instructions to cross off the names of any arbitrators considered unsuitable and to number the rest in order

of preference. By comparing the parties' choices, AAA was able to appoint a mutually acceptable arbitrator.

Next, a convenient hearing date was scheduled. The parties showed up for the hearing accompanied by their attorneys and witnesses. The arbitrator, an attorney, took about five hours to hear the evidence.

The key to the issue was contract language stating that "The *payment* of super-specialist services must be authorized by the chairman of the medical board of the health plan."

The arbitrator quickly concluded that officials of the health plan had intended for the medical group to obtain authorization of super-specialist services, but had not made that intention clear enough in the contract. Instead of requiring authorization of "payment" for such services, the contract should have required authorization of "performance" of the services. That way there would have been no mistaking the intended effect.

At any rate, the arbitrator held the ambiguity against the health plan since it had drawn the contract. He ordered the bill paid in full and at the same time forbade the medical group to again engage a super-specialist without the board's approval. The parties received the award as required, within 30 days after the hearing.

Another case, this one involving a whole medical group, settled a dispute between a West Coast clinic and "Mr. D." The parents of an injured child alleged that certain physicians of the group failed to use their "skill, learning, care and diligence" in examining and treating their child's illness and that they seriously aggravated her condition, injured her nervous system and crippled her body. After two days of hearings, the claim was denied thus avoiding a long drawn out court proceeding and, even with a favorable decision, unfavorable publicity.

Court decisions are affirming the responsibility of medical enterprises for all of the mishaps occurring in their operation, including those caused by non-medical employees. As a result, malpractice insurance costs have soared: Both the cost of individual premiums and the need for multiple and duplicating coverages for the enterprise — whether it be hospital or clinic. Physicians of course must be covered, but so must nurses, technicians and even non-medical employees. Arbitration of more such claims could reduce the cost of litigation and would probably result in decisions conforming more to the technical facts in the case, without reducing professional responsibility that is so essential to protect the public.

You may well ask — if arbitration is so favorable to the physician, why should the patient's attorney be willing to accept this process. There are also advantages to the patient in arbitration of malpractice cases. In addition to the elements of speed and economy, the patient may also prefer privacy. He may feel that there is more likelihood of obtaining expert medical testimony in arbitration than in a court, or that, with a man competent to judge medical facts sitting as an arbitrator, there is less need of such testimony.

Insurance companies have also become increasingly interested in arbitration of cases of this sort. While it is by no means common practice today, many insurance companies have publicly indicated their willingness, if requested, to submit such cases to arbitration. There is now a more favorable attitude on the part of both negligent attorneys and insurance companies to go to arbitration than ever before.

If you are party to a contract or are about to be, including an arbitration clause will insure your keeping out of the courts if a dispute arises. Or, if you do get into a dispute and no such clause exists in the contract, you may still be able to take the case to arbitration as an alternative to the courts if your adversary is willing.

Arbitration, however, is not to be considered a panacea. Some controversies are better left to the courts. Most attorneys recommend arbitration for determination of issues of performance, problems arising in partnerships, close corporations and joint ventures, in situations where knowledge of trade or professional usage is desirable, to determine property valuation and damage and personal injury.

Matters involving novel points of law or complicated issues of fact are usually better decided by courts. Attorneys also discourage arbitration when a decision according to law is wanted and when appellate review is desirable.

Arbitration, however, does serve in most of the ordinary disputes confronted in the medical office. It is fair, fast and highly favorable — taken as indicated.

There is an Arizona Regional office located at Suite 242 Luhrs Central Building, 132 South Central Avenue, Phoenix, Arizona 85004. Mr. Paul A. Newnham is its Regional Manager.



Medical History

James Cooper McKee, M.D.
1830-1897

Photograph courtesy National Library of Medicine

Audrey Davis Stevens

It is an understatement to say that medical records, from frontier Army forts, are scarce. Actually they are almost non-existent. Many records were lost in transit to Washington, D.C., others are, by our present day standards, incomplete or have been destroyed.

Dr. James Cooper McKee wrote three articles contributing interesting tid-bits to Arizona's medical history.

The first was written (1878) while he was stationed at Fort Whipple, "Narrative of the Surrender of a Command of United States Forces at Fort Fillmore, New Mexico." This pamphlet was originally published in Prescott and recently republished by the Stage Coach Press, Houston, Texas. It contains an extensive criticism of Major Lyndes' timidity and unconditional surrender to the Confederates on July 27, 1861.[1]

His second article (1880) reports a gastrotomy performed by him at Fort Whipple Hospital.[2] This was one of the earliest operations of this type reported in the United States and almost certainly the first successful gastrotomy performed in Arizona.

The patient was a young exhibitionist miner from Tip Top, Arizona, whose slight of hand tricks ended in the young pioneer having a three-inch copper wire slip from its hiding place, inside his nose, down the pharynx and into his stomach. After two months of self doctoring, the patient, Joe Tudor, was taken by "ambulance" over the rough countryside to Fort Whipple where he was observed for a period of 49 days. At the insistence of the patient, Dr. McKee finally operated.[3]

The operation was performed under "Lister's antiseptic process." An incision of about 3½ inches in length was made to the right of the umbilicus and increased to 4½ inches. A pair of forceps were used to extract the wire. Silver wire sutures were used, and antiseptic bandages were wound around and around the patient's body.

In the evening after surgery, the independent frontiersman awakened and when told by Dr. McKee that the wire had been found and removed, expressed an opinion about it more forcible than polite, and again relapsed into sleep. Fifteen days later the dressings had been removed and he was allowed to sit up and walk around the barracks of Fort Whipple.

Dr. McKee's last article, written in 1891, concerns his life in New Mexico and Arizona Territories during the late 1850's and fall of 1860. According to this Dr. McKee served as medical

officer for a year and a half at Fort Defiance and had been in two campaigns against the Indians. One of these campaigns took place, during the winter of 1858, in the Pinal mountains, north of the Gila River. This campaign was under Captain Washington L. Elliott. For a total of three years he had served under such men as: Richard S. Ewell, R. S. C. Lord, John P. Hatch, William B. Lane, William W. Averell, F. I. Crilly and others.[4]

It is too bad that Dr. McKee did not write more of his experiences. After graduating from the medical department of the University of Pennsylvania (1852) he practiced medicine for five years in Hollidaysburg and Altoona, Pennsylvania. In 1857 he became a contract surgeon for the United States Army and then a commissioned officer in 1858. In 1861 he was a prisoner of the Confederate Army. Shortly thereafter he was exchanged and organized an army hospital in Chester, Pennsylvania. As assistant medical supply officer he participated in the second Battle of Bull Run (August 1862) and in the Battle of Antietam. During this same year he organized a general hospital in Pittsburgh, Pennsylvania. From 1863 until the end of the Civil War he was director of the 3,000 bed Lincoln Hospital, Washington, D.C. It has been estimated that during his directorship over 25,000 men were treated in this hospital.

Shortly after the war he returned to the West. He was stationed at Fort Whipple and at one time was Medical Director of the Department of Arizona. Toward the end of his army career he served as chief medical officer at Santa Fe, New Mexico; Vancouver Barracks, Washington Territory; and Fort Wadsworth, New York.

Dr. McKee retired as a Lieutenant Colonel in 1891 and returned to the place of his birth, Butler, Pennsylvania. In 1897 he died of a heart attack while talking to his physician. Though he never married he left among his survivors, four adopted children and probably the grateful gastrotomy patient from Tip Top, Arizona.[5]

Acknowledgement

A special "thank you" to Miss Frances R. Houston, Executive Secretary, The Medical Alumni Society, University of Pennsylvania.

Footnotes

1. Sacks, B., **Be It Enacted: The Creation of the Territory of Arizona,** (Phoenix: Arizona Historical Foundation, 1964), p. 62 and 99.
2. McKee, J. C., "Foreign Body in the Intestines — Operation and Recovery," **Medical Record,** (New York: 1880), Vol. 15, pp. 607-608.
3. Ibid.
4. McKee, p. 387. (See Note 1.)
5. Collection of Newspaper Clippings (1897) from the Archives of the University of Pennsylvania.

In Memoriam

CHARLES B. HUESTIS, M.D.
1895-1968

Charles B. Huestis, M.D., widely known Arizona physician, died in Phoenix, Arizona on September 22, 1968.

Born April 1895, in Omaha, Nebraska, Dr. Huestis received his medical degree from the University of Nebraska Medical School in 1920. After hospital training in New York he came to Arizona in 1924 and was physician in charge for Kennecott Copper Corporation in Hayden, Arizona. He spent the following years there until he retired in 1960, when he moved to Phoenix.

During the depression years in the thirties he was many times the only doctor in Hayden and the large surrounding territory. He took wonderful care of everyone, many of them out of work and pinched financially. He was not only their doctor but also their counselor, health officer, social worker, trouble shooter and true friend.

When World War II started he was declared essential to his copper producer community so could not offer his services to the armed forces. With doctors and nurses leaving for the services he had a load that few could have carried. Always cheerful, no one ever heard any word of complaint from him. He was as dearly loved by his patients and by his medical associates as was any doctor of medicine that I have ever known. It was my privilege and pleasure to have worked with him during these many years.

Dr. Huestis was a member of the Maricopa County Medical Society, the Arizona State Medical Association and the American Medical Association. During his retirement years he spent many hours weekly as a volunteer at the Maricopa County General Hospital.

Dr. Huestis was a member of the Winkelman Masonic Lodge. He became Grand High Priest of the Royal Arch Masons of Arizona in 1938, and in 1945 he served as Grand Master of the Masonic Grand Lodge of Arizona.

Dr. Huestis is survived by a son, Charles D. Huestis of Ottawa, Illinois, a daughter, Mrs. W. R. Welty, Fullerton, California, and three grandchildren.

Otto E. Utzinger, M.D.

Federal Medical Programs

HISTORY AND PURPOSES OF THE ARIZONA REGIONAL MEDICAL PROGRAM

I. History and Purposes of the Arizona Regional Medical Program

The President's 1964 health message to Congress called for a Commission on Heart Disease, Cancer and Stroke, "to recommend the steps to reduce the incidence of these diseases through new knowledge and more complete utilization of medical knowledge we already have." The Commission's subsequent recommendations formed the basis for heart disease, cancer and stroke amendments of 1965 to the U.S. Public Health Service Act, officially known as Public Law 89-239.

The basic premise behind this legislation is that medical knowledge is expanding at an exceedingly rapid rate and, as a consequence, the latest advances in the diagnosis and treatment of these serious diseases were not being disseminated and applied rapidly throughout the health-care system of the country. To improve the availability and quality of health services, the Law establishes a system of grants to assist in the establishment of Regional Medical Programs. The Law also applies a new concept of government administration and brings medical colleges into the planning, support and operation of health programs for the improvement of quality and availability of health services to patients suffering from heart disease, cancer and stroke.

In 1967, the United States Public Health Service awarded a grant to the University of Arizona College of Medicine for the establishment of the Arizona Regional Medical Program, and the region to be served has been defined as the entire State of Arizona.

In compliance with this legislation, the Dean of the College of Medicine appointed a broadly representative Regional Advisory Group. This group includes practicing physicians, hospital and health administrators, medical center officials, other health professionals, and representatives from professional societies, voluntary associations and the public. All are familiar with Arizona needs for the services provided under the Program. It is the function of this group to provide overall guidance to the College of Medicine in the planning, operation and evaluation of the Arizona Regional Medical Program. While the group does not have direct administrative responsibility for the program, the Act specifies that it must approve all applications for operational grants.

Basic to the philosophy of the Act is that Regional Medical Programs can best be effected at the local level by those who are providing health care in the region and who will be involved in the implementation of the Program. It is also recognized that, because of the rapid advances in medicine and the increased complexity of services required, there is need for a greater interdependence among the various components of the health-care system. The increasing scarcity of staff, the cost of medical care and the cost of increasingly complex health facilities and equipment make it necessary to apply all of the health resources in a coordinated and efficient

manner if the patient is to be fully benefited by the latest advances in medical science.

The Arizona Regional Medical Program intends to serve as a catalyst in expanding existing programs, in providing new programs and in creating voluntary cooperative arrangements among various agencies and institutions. This kind of action is necessary to make limited manpower and facilities generally available to patients and to link the patient with the latest advances in research and education.

The process of cooperation and regionalization of all health resources should be looked upon as a continuous process extending into the indefinite future. It also follows that if the Arizona Regional Medical Program is to remain viable, be progressive and keep abreast of new developments as they occur, a number of dynamic interrelated elements will be necessary:

1. Involvement

 Basic to the concept and success of the Arizona Regional Medical Program are the involvement and commitment of large numbers of representative individuals, health facilities and institutions of higher learning in the provision of health services to citizens of the State of Arizona. Planning must start at the local level by those individuals and groups closest to the community problems who know best the needs of the community and the resources that are available to meet the need. This local involvement will assure better solutions for each community and increase the rate of application and acceptance of new knowledge.

2. Identification of Needs and Community Resources

 Each community must identify its health needs and the resources that are available to attack the health problems. This process should result in the identification of gaps in service and lead to the development of a plan to improve the health services available to patients. The Arizona Regional Medical Program staff will assist in this process, evaluate the needs on a regional basis and work with the communities, public and private agencies and health facilities in the development of a coordinated plan to meet the total needs of the geographic area.

3. Goals and Objectives

 The Arizona Regional Medical Program goals are improved care for patients, and a decrease in the incidence, morbidity, mortality and disability in Arizona residents who are suffering from Heart, Cancer, Stroke and Related Diseases.

 Within these broad program goals the Arizona Regional Medical Program will continuously set operational objectives to be met in resolving regional needs. Major objectives will include:

 a. To develop regional cooperative arrangements among the full array of health resources in the region.
 b. To improve health facilities, equipment and professional and technical services available to patients within each region who are suffering from Heart, Cancer, Stroke and Related Diseases.
 c. To bring, as rapidly as possible, the benefits of scientific advances in medicine to patients suffering from Heart, Cancer, Stroke and Related Diseases.
 d. To improve the efficiency, availability, quantity and quality of health personnel in the region.

4. Priorities

 Because of limited resources of manpower and facilities, it will be necessary to establish an order of priority for the local and regional objectives of the program. The programs developed will reflect an appropriate balance of emphasis on patient care, education, research, short and long-term progress, use of existing resources, improved efficiency, creation of new resources and reduced costs.

5. Implementation

 The steps described above provide the basis for an operational Regional Medical Program in Arizona. Implementation must reflect sound administration of operational projects, be within the context of program philosophy and be directed towards the goals and objectives of the program.

6. Evaluation

 Qualitative and quantitative evaluation of all projects at all levels will receive continuous attention and be an integral part of the system design of every project. It will be necessary for each project to define specific problems and objectives in such a manner that progress toward the goals and objectives of the program can be readily measured and evaluated.

II. Eligible Applicants

Public Law 89-239 states:

"Sec. 904 (a) Surgeon General, upon the

recommendation of the Council, is authorized to make grants to public or non-profit private universities, medical schools, research institutions and other public or non-profit private agencies and institutions to assist in establishment and operation of Regional Medical Programs, including construction and equipment of facilities in connection therewith."

III. Elements in Grant Applications

Fundamental to the Arizona Regional Medical Program is the goal of improved patient care for patents suffering from Heart, Cancer, Stroke and related Diseases. Further, the Surgeon General's report states this goal as ". . . clear and unequivocal. The focus is on the patient. The object is to influence the present arrangements for health services in a manner that will permit the best in modern medical care for heart disease, cancer, stroke, and related diseases to be available to all."

With these fundamental goals and objectives clearly in mind, all projects in the developmental stage should give descriptive answers to significant questions such as:

1. How does the project further the goals and objectives of the Arizona Regional Medical Program?
2. How does the project meet a need that has been identified by the community, Arizona Regional Medical Program or by an advisory committee?
3. How does the project demonstrate a high probability of improving patient care?
4. Is the project compatible with existing patterns of health care or, if not, does the project demonstrate support for new or innovative approaches by the cooperating facilities and health agencies in the geographic area to be served? (If research is an element, does the project show a relationship to the goals and objectives of the program and demonstrate potential for improved patient care?)
5. How does the project show cooperation between two or more health institutions or agencies within the region? How has inefficiency and duplication been avoided?
6. Does the project have professional and technical merit? How?
7. Does the project have elements of continuing and/or public education? How much and what kind?
8. Does the project place emphasis on:
 a. Prevention of disease?
 b. Early diagnosis and prevention of complications of Cancer, Heart Disease and Stroke?
 c. Return to productive life of the patient?
 d. Continuity of treatment across the whole broad spectrum of health services?
9. Does the project demonstrate that grant funds will not supplant funds otherwise available; and have all health resources available in the region been considered?
10. What are the facilities and are there personnel available to implement the project? Does the project show improved efficiency in the use of manpower? How?
11. Is evaluation an integral part of the project?
12. Does the project have regional implications? Does it have potential for other RMP Regions? Explain.
13. Have provisions been made for voluntary support, active participation at the community level and contributions? How will the project be continued on expiration of the grant?
14. How does the project demonstrate maximum results with minimum costs?

IV. Criteria for Funding

It is recognized that program objectives will change from time to time as the situation within the region evolves. For current purposes, staff and study committees will consider the following elements and questions in establishing priorities and making recommendations on proposals submitted to the Arizona Regional Medical Program.

1. Basic eligibility
 a. Is the project oriented primarily for the solution of problems associated with Heart, Cancer, Stroke and Related Diseases?
 b. Is there ample evidence of the non-profit status of the applicant, organization or institution?
 c. Has local professional responsibility been identified and established for all health service elements in the project?
 d. Has duplication of services and supplanting of services and/or funds been avoided?
 e. If renovation is involved in the project, have all guideline requirements been met?
 f. Is the project compatible with existing patterns of medical care and hospital operation?
 g. Does the applicant organization(s) or institution(s) make a contribution toward

the attainment of the project objectives? (e.g., contribution of personnel services, alteration of space, purchase of equipment and supplies, travel and per diem for employees, overhead costs for the project, communication costs, printing, etc., can all be considered.)

h. Is the applicant capable of conducting the project in a manner which has reasonable assurance that the goals and the objectives of the project will be met?

2. Relevance to Goals and Objectives — Arizona Regional Medical Program
 a. Does the project further cooperation and coordination of health activities between two or more agencies and institutions?
 b. Is patient care improved?
 c. Does the project make a significant impact on the disease entity(ies) in the region through improvement in the availability of health services?
 d. Does the project accelerate the application of new knowledge through elements of continuing education, training and demonstration?
 e. If purchase of equipment is included in the project does it meet a demonstrated regional need or, if not, will it be used for continuing education, training and demonstration purposes?
 f. Does the project have relevance to other than strictly local needs? (Projects designed to meet the needs of a single institution and which have no regional significance will ordinarily not be funded.)
 g. Does the project have a reasonable chance for eventual funding from other sources if it has proved worthwhile? (RMP funds should not be considered as a permanent source for future funding.)
 h. Does the project improve efficiency or reduce costs?
3. Relevance to Local Needs
 a. Have local needs been identified and adequately documented?
 b. Have all other resources available to meet the need been identified? How will these resources be coordinated and used in furthering the objectives of the project?
 c. What specific needs will be fulfilled?
 d. Have representatives from the community been involved in the planning and execution of the project?
4. Relevance to National Objectives of Regional Medical Program
 a. Can the project results be applied in other parts of the region or nation?
5. Evaluation
 a. Is an adequate evaluation procedure an integral part of the system design of the project?

V. Priorities for Funding

Limitation of resources and competition for funding of projects at the national level make it imperative that priorities be established for the submission of projects by the College of Medicine to the National Regional Medical Program.

Priority must be considered within the context of the objectives of both the National and Arizona Regional Medical Programs. Provisions will be made to insure a balanced development of the Arizona Regional Medical Program.

The group of projects submitted should be balanced with respect to disease categories, scope of impact, continuing education and training and the possibility of early payoff. Thus, projects with greater impact for a given expenditure of funds will receive a higher priority than those of lesser impact.

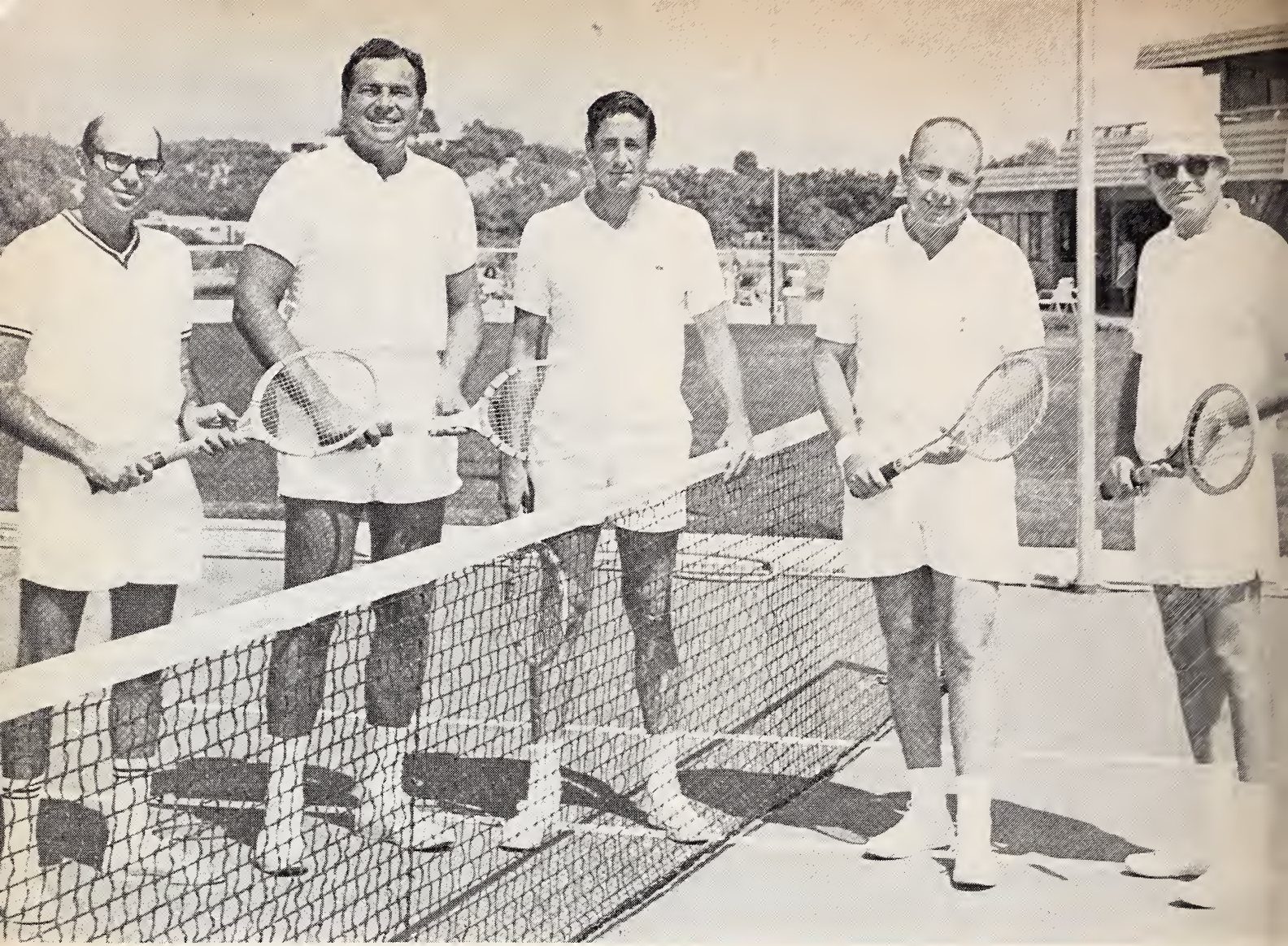
Evaluation of the merits of any submitted project rests with the Arizona Regional Advisory Group and with the National Advisory Council. Thus, inasmuch as the competition for funds is on a national basis the projects should, in addition, be professionally and technically sound.

VI. Procedure for Submission of Project Proposals to the Arizona Regional Medical Program

Individual health professionals, or representatives of health agencies, health facilities, research institutes and other public non-proft, privatc agencies and institutions wishing to submit projects to the Arizona Regional Medical Program for review and approval should contact the following offices and request the document "Project Planning and Proposal Preparation."

The University of Arizona
College of Medicine
Arizona Regional Medical Program
Tucson, Arizona 85721
Tucson Phone: 884-2935

Arizona Regional Medical Program
100 West Clarendon Road - Suit 1646
Phoenix, Arizona 85013
Phoenix Phone: 277-3325



THESE PHYSICIANS INVITE YOU TO THE AMTA TENNIS VACATION IN TUCSON NEXT FEB. 12-15. (L-R) BOB HIRSCH, BILL EBERLING, JOHN HOLBROOK, BILL KOHL (CHAIRMAN) AND SAM GRABB.

AMERICAN MEDICAL TENNIS ASSOCIATION

1969 National Winter Tennis Tournament

February 12 through 15, 1969

Tucson, Arizona

(Headquarters Hotel: Statler Hilton Inn)

Deadline for entries: January 1, 1969

For Further Information Contact:
Harold W. Kohl, Jr., M.D.
Post Office Box 1561
Tucson, Arizona 85702



This is official notification that the American Medical Tennis Association will hold its 1969 National Winter Tennis Tournament in Tucson on February 12, 13, 14, 15, 1969.

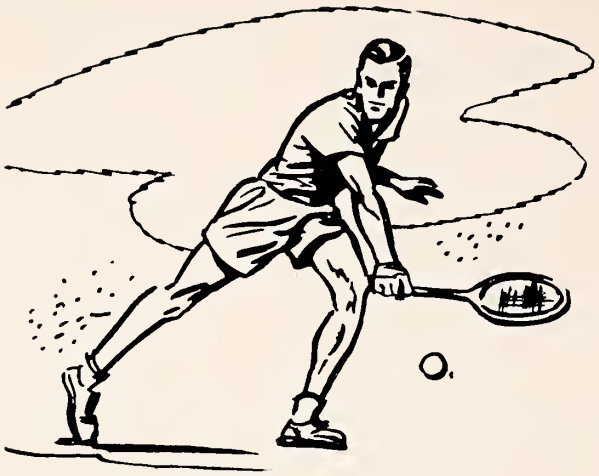
The AMTA is a national organization of tennis playing physicians established about a year ago. Its present membership numbers about 800. It is the counterpart of the American Medical Golf Association which has been in existence for some years.

We expect some 300 physicians and wives to participate in the 1969 Winter Tournament in Tucson and believe that ArMA should be aware that this many physicians from all over the country will be in Arizona as a group.

In addition to the tennis tournament itself, there will also be a scientific program and several evening social events.

The headquarters hotel will be the Statler Hilton Inn and the main tennis playing site will be the Tucson Racquet and Swim Club. Other tennis courts throughout the city will be available for play as necessary. We will give each entrant the opportunity to play all the tennis he wishes even if he is eliminated from actual tournament play.

The Arizona committee consisting of about 35 Tucson physicians has worked very hard in planning this event and we expect it to be a great success. It will be a fine opportunity for Arizona physicians to meet doctors from other parts of the country. Many of those in attendance will no doubt wish to visit other parts of the state while they are here.



TENNIS LOVERS — UNITE!

An invitation to physicians to join in the formation of the brand-new American Medical Tennis Association . . . exclusively for physicians.

Several months ago I submitted an article to Rx GOLF and TRAVEL magazine; an article which was concerned with the incomparable sport of tennis.

Since publication of that article in the July/Aug. issue of Rx G&T, the editors and I have received mail and telephone calls from tennis-playing physicians who live in all parts of the United States.

Dr. McGannon:

I want to be a member of the American Medical Tennis Association (AMTA). My check for $10 (made out to Director, AMTA) is enclosed to cover my life-time dues.

NAME:

AGE:

ADDRESS:

I belong to the following tennis organizations:

(Please include any suggestions or comments which you feel will be helpful.)

Mail to: Dr. William J. McGannon, c/o The American Medical Tennis Association, Rx GOLF and TRAVEL Magazine, Box 25125, Okla. City, Olka. 73125.

The letters and calls, without exception, have been enthusiastic corroboration of my views and many of the correspondents have urged the formation of an organization for physicians who are tennis lovers.

There are many services that such an organization could perform. One of the most important would be the compilation of a directory of members living all over the U. S. so that when away from home, a member could contact an associate by referring to the directory and arrange for a session on the court.

The planning and conducting of tennis activity in conjunction with medical meetings would be well-received judging from the sentiments that have been expressed. And certainly, the service of encouraging participation by physicians and their families in tennis would seem worthwhile.

This will be the first effort to get formal membership applications from those of you who are interested in organizing the AMERICAN MEDICAL TENNIS ASSOCIATION (AMTA). It will, of course, be non-profit, and the life-time membership fee of $10 is proposed only to help with the administration.

During the organization period, Rx G&T has offered to take care of the publicity and to assist with whatever administrative help will be needed. News of upcoming events and pictures and stories of those events will be reported in Rx GOLF and TRAVEL, the sports and leisure magazine published exclusively for physicians.

Please use the coupon to join in this group of tennis enthusiasts. Your comments and suggestions are solicited and will be appreciated.

ARIZONA MEDICAL ASSOCIATION – STATE DEPARTMENT OF HEALTH

Recommended Immunization Schedules

JANUARY 1967

	VACCINE	MINIMUM AGE TO START	ROUTE OF IMMUNIZATION	NUMBER OF DOSES IN PRIMARY SERIES	INTERVALS IN PRIMARY SERIES	SEQUENCE SCHEDULE BY AGE: 2-3 MONTHS	3-4 MONTHS	4-5 MONTHS	11-12 MONTHS	12 MONTHS AND OVER	15-18 MONTHS	3 YEARS	6 YEARS	8 YEARS	12 YEARS	16 YEARS AND OVER	REMARKS
ROUTINE-USE RECOMMENDATIONS	ROUTINE DIPHTHERIA PERTUSSIS AND TETANUS (DPT) (PEDIATRICS)	2 MONTHS	INTRAMUSCULARLY	3	1 MONTH	0.5 cc	0.5 cc	0.5 cc	--	--	0.5 cc	0.5 cc	NOT GIVEN	NOT GIVEN	NOT GIVEN	NOT GIVEN	
	TETANUS DIPHTHERIA (TD ADULT)	6 YEARS	INTRAMUSCULARLY	3	1 MONTH BETWEEN 1st AND 2nd 1 YEAR BETWEEN 2nd AND 3rd	NOT GIVEN	NOT GIVEN	NOT GIVEN	NOT GIVEN	NOT GIVEN	NOT GIVEN	NOT GIVEN	0.8 cc	--	0.5 cc	--	AFTER 12 YEARS OF AGE, ADULT TD TOXOID BOOSTER SHOULD BE GIVEN EVERY 10 YEARS OR 10 YEARS AFTER USE IN INJURY.
	SMALLPOX	12 MONTHS	PERCUTANEOUSLY BY MULTIPLE PRESSURE TECHNIQUE	1	--	NOT GIVEN	NOT GIVEN	NOT GIVEN	NOT GIVEN	--	1 DROP	--	1 DROP	--	1 DROP		INITIAL SMALLPOX VACCINE MAY BE GIVEN AT ANY TIME BETWEEN 12 AND 2M MONTHS OF AGE. AFTER AGE 12, BOOSTERS GIVEN EVERY 5 YEARS EXCEPT AT TIME OF INTERNATIONAL TRAVEL OR HIGH RISK GROUPS WHO SHOULD BE VACCINATED EVERY 3 YEARS.
	POLIOMYELITIS LIVE, ORAL, MONOVALENT TYPES I, II, III	2 MONTHS	ORAL	1 OF EACH TYPE	1 MONTH TO 6 WEEKS	TYPE I QUANTITY AS RECOMMENDED BY MANUFACTURER	TYPE III QUANTITY AS RECOMMENDED BY MANUFACTURER	TYPE II QUANTITY AS RECOMMENDED BY MANUFACTURER	--	--	--	--	--	--	--	--	UPPER AGE LIMIT FOR OPV IS 18 YEARS. ADULTS SHOULD BE VACCINATED WITH OPV ONLY UNDER SPECIAL CIRCUMSTANCES OF INCREASED EXPOSURE, I.E., ENTRY INTO MILITARY SERVICE, FOREIGN TRAVEL, OR ENTRANCE INTO HIGHLY ENDEMIC AREA.
	LIVE, ORAL TRIVALENT (OPV)	2 MONTHS	ORAL	3	1 MONTH TO 6 WEEKS	QUANTITY AS RECOMMENDED BY MANUFACTURER	QUANTITY AS RECOMMENDED BY MANUFACTURER	QUANTITY AS RECOMMENDED BY MANUFACTURER	--	--	QUANTITY AS RECOMMENDED BY MANUFACTURER	--	QUANTITY AS RECOMMENDED BY MANUFACTURER	--	--	--	A DOSE OF TRIVALENT OPV MIGHT BE CONSIDERED FOR ANYONE ENTERING A HIGHLY ENDEMIC AREA REGARDLESS OF PREVIOUS VACCINATION HISTORY.
	MEASLES*																
	1. LIVE* ATTENUATED VACCINE (EDMONSTON)	12 MONTHS OR OLDER	SUBCUTANEOUSLY (VACCINE)	1 INJECTION	--	NOT GIVEN	NOT GIVEN	NOT GIVEN	NOT GIVEN	QUANTITY AS RECOMMENDED BY MANUFACTURER							SIMULTANEOUS ADMINISTRATION OF MIG WITH EDMONSTON STRAIN VACCINE REDUCES FREQUENCY OF UNDESIRED REACTIONS.
	2. LIVE* ATTENUATED VACCINE (EDMONSTON) PLUS MEASLES IMMUNE GLOBULIN	12 MONTHS OR OLDER	VACCINE SUBCUTANEOUSLY, IMMUNE GLOBULIN INTRAMUSCULARLY 1.022 ML/Kg WITH DIFFERENT SYRINGE)	2 INJECTIONS (1 VACCINE AND 1 MEASLES IMMUNE GLOBULIN)	SAME TIME DIFFERENT SITES	NOT GIVEN	NOT GIVEN	NOT GIVEN	NOT GIVEN	QUANTITY AS RECOMMENDED BY MANUFACTURER							SCHEDULES 1, 2, 3 ARE PREFERRED OVER KILLED VACCINE REGIMENS EXCEPT WHEN LIVE VACCINE IS CONTRAINDICATED. CHILDREN WITH ALTERED IMMUNE RESPONSE (E.G. LEUKEMIA, THERAPY WITH ANTIMETABOLITES, STEROIDS, ALKYLATING AGENTS AND IRRADIATION) SHOULD RECEIVE INACTIVATED VACCINE. CHILDREN WITH TB SHOULD BE ON THERAPY BEFORE GIVEN LIVE MEASLES VACCINE.
	3. LIVE* FURTHER ATTENUATED VACCINE (SCHWARZ)	12 MONTHS OR OLDER	SUBCUTANEOUSLY WITHOUT MIG	1 INJECTION	--	NOT GIVEN	NOT GIVEN	NOT GIVEN	NOT GIVEN	QUANTITY AS RECOMMENDED BY MANUFACTURER							
	A. INACTIVATED* VACCINE FOLLOWED BY LIVE, ATTENUATED VACCINE	12 MONTHS OR OLDER	SUBCUTANEOUSLY	2 (SEE REMARKS)	1-3 MONTHS	NOT GIVEN	NOT GIVEN	NOT GIVEN	NOT GIVEN	QUANTITY AS RECOMMENDED BY MANUFACTURER							
	B. INACTIVATED* VACCINE FOLLOWED BY LIVE, ATTENUATED VACCINE	UNDER 12 MONTHS	SUBCUTANEOUSLY	4	1 MONTH	QUANTITY AS RECOMMENDED BY MANUFACTURER	QUANTITY AS RECOMMENDED BY MANUFACTURER	QUANTITY AS RECOMMENDED BY MANUFACTURER		BOOSTER WITH 1 DOSE LIVE ATTENUATED VACCINE							
	INFLUENZA*	3 MONTHS	SUBCUTANEOUSLY	2	2 MONTHS	0.2 cc	--	0.2 cc	--	--							NORMAL CHILDREN DO NOT REQUIRE INFLUENZA IMMUNIZATION. CHILDREN 3 MONTHS TO 5 YEARS 0.2 cc; CHILDREN 6-12 YEARS 0.5 cc. ADULT 1.0 cc. BOOSTER 1 PER YEAR TO BE COMPLETED BEFORE MID-DECEMBER.
	TYPHOID	6 MONTHS	SUBCUTANEOUSLY	2	4 WEEKS	NOT GIVEN	NOT GIVEN	CHILDREN 6 MONTHS TO 2 YEARS 0.25 cc ON TWO OCCASIONS SEPARATED BY 4 OR MORE WEEKS							CHILDREN OVER 10 AND ADULTS 0.5 cc ON 2 OCCASIONS SEPARATED BY 4 OR MORE WEEKS.		BOOSTER EITHER 0.5 cc SUBCUTANEOUSLY OR 0.1 cc INTRADERMALLY IF OVER 10 YEARS. BOOSTER 0.25 cc SUBCUTANEOUSLY OR 0.1 cc INTRADERMALLY IF UNDER 10 YEARS, DUE EVERY 3 YEARS UNDER CONDITIONS OF EXPOSURE, FOREIGN TRAVEL, COMMUNITY OUTBREAKS, ETC.
	PARATYPHOID	--	--	--	--	USE OF PARATYPHOID A & B VACCINE IS NOT RECOMMENDED											THE EFFECTIVENESS OF PARATYPHOID A VACCINE HAS NEVER BEEN ESTABLISHED, AND RECENT FIELD TRIALS HAVE SHOWN PARATYPHOID B VACCINE WERE INEFFECTIVE. IT IS ALSO RECOGNIZED THAT PARATYPHOID A & B ANTIGENS, WHEN COMBINED WITH TYPHOID VACCINE MAY INCREASE OCCURRENCE OF REACTIONS. THUS USE OF PARATYPHOID A & B VACCINES IS NOT RECOMMENDED.
AUX-AUXILIARY USE RECOMMENDATIONS	CHOLERA	6 MONTHS	INTRAMUSCULARLY OR SUBCUTANEOUSLY	ADULTS 2 CHILDREN 3	7 DAYS 7 DAYS	NOT GIVEN	NOT GIVEN	NOT GIVEN	AGE 6 MONTHS TO 4 YEARS 1st DOSE - 0.1 cc 2nd DOSE - 0.3 cc 3rd DOSE - 0.3 cc			AGE 5 YEARS TO 9 YEARS 1st DOSE - 0.3 cc 2nd DOSE - 0.5 cc 3rd DOSE - 0.5 cc		AGE 10 YEARS AND OVER 1st DOSE - 0.5 cc 2nd DOSE - 1.0 cc			RECOMMENDED FOR TRAVELERS TO AND FROM VARIOUS ASIATIC COUNTRIES. A RECALL INJECTION IS RECOMMENDED EVERY 4-6 MONTHS WHILE IN AN INFECTED AREA.
	PLAGUE	6 MONTHS	INTRAMUSCULARLY OR SUBCUTANEOUSLY	ADULTS 2 CHILDREN 3	7-28 DAYS 7 OR MORE DAYS	NOT GIVEN	NOT GIVEN	NOT GIVEN	AGE 6 MONTHS TO 4 YEARS 1st DOSE - 0.1 cc 2nd DOSE - 0.3 cc 3rd DOSE - 0.3 cc			AGE 5 YEARS TO 9 YEARS 1st DOSE - 0.3 cc 2nd DOSE - 0.5 cc 3rd DOSE - 0.6 cc		AGE 10 YEARS AND OVER 1st DOSE - 0.5 cc 2nd DOSE - 1.0 cc			BOOSTER EVERY 4-6 MONTHS IN ENDEMIC AREA, OTHERWISE WITH DOSAGE ACCORDING TO AGE EVERY 4 YEARS FOR RECALL INJECTION.
	TYPHUS*	6 MONTHS	INTRAMUSCULARLY OR SUBCUTANEOUSLY	3	ADULTS 1.0 cc FOLLOWED IN 1-3 WEEKS BY 1.0 cc FOLLOWED IN 1 YEAR BY 1.0 cc CHILDREN 3 INJECTIONS AT 1-3 WEEK INTERVAL	NOT GIVEN	NOT GIVEN	NOT GIVEN	AGE 6 MONTHS TO 4 YEARS 0.2 cc			AGE 5 YEARS TO 9 YEARS 0.5 cc		AGE 10 YEARS AND OVER ADULT SCHEDULE			1 RECALL INJECTION RECOMMENDED ANNUALLY WITH DOSE ACCORDING TO AGE WHILE IN ENDEMIC AREAS.
	YELLOW FEVER	6 MONTHS	INTRAMUSCULARLY OR SUBCUTANEOUSLY	1	--	0.5 cc FOR ALL AGE GROUPS											BOOSTER OF 0.5 cc EVERY 6 YEARS. RECOMMENDED FOR TRAVEL TO CENTRAL OR SOUTH AMERICA OR ANY AFRICAN COUNTRY BELOW THE SAHARA, AVAILABLE BY APPOINTMENT AT THE FOLLOWING LOCAL HEALTH DEPARTMENTS COCONINO COUNTY, MARICOPA COUNTY, AND PIMA COUNTY.
	ROCKY MOUNTAIN SPOTTED FEVER*		INTRAMUSCULARLY OR SUBCUTANEOUSLY	3	7 DAYS	NOT GIVEN	NOT GIVEN	NOT GIVEN	QUANTITY AS RECOMMENDED BY MANUFACTURER FOR AGE								RECOMMENDED ONLY FOR WORKERS WITH HIGH OCCUPATIONAL RISK. ANNUAL BOOSTER OF 0.5 cc NEEDED.

* CONTAINS EGG PROTEIN

PREPARED BY:
ARIZONA STATE JOINT IMMUNIZATION COMMITTEE

APPROVED BY:

ARIZONA MEDICAL ASSOCIATION
ARIZONA ACADEMY OF GENERAL PRACTICE
ARIZONA SOCIETY OF INTERNAL MEDICINE
ARIZONA SOCIETY OF PEDIATRICS
ARIZONA OSTEOPATHIC MEDICAL ASSOCIATION
ARIZONA STATE BOARD OF HEALTH
ARIZONA ASSOCIATION OF HEALTH OFFICERS

Future Medical Meetings

The University of Southern California School of Medicine will again sponsor a course in psychiatry for medical practitioners. The course will consist of twelve two-hour sessions at weekly intervals starting Tuesday, January 21, 1969, 7:00 p.m., at Arizona State Hospital, and is open to all physicians.

Whereas the 1968 course was essentially limited to interviewing techniques and facilitation, the 1969 course will stress further exploration of the emotional aspects of the patient's problems, and enter into interpretive, psycho-diagnostic and therapeutic aspects.

As in the initial course, both tapes and live interviews (patients will be provided by the course participants) will be used. There will, however, be NO division of the class, limiting either section to separate formats of instruction — i.e., all of the participating "students" will have the benefit of BOTH taped and live interviews.

It is planned, also, to enlist the participants in the conducting of some of the interviews. Further, some of the patients will be followed on beyond the initial interview into further visits.

The enrollment fee is $35.00 and Class I credit for the AAGP will be given for those desiring it. Application blanks may be obtained from:

University of Southern California School of Medicine

Division of Post-Graduate Psychiatry

2025 Zonal Avenue

Los Angeles, California 90033

Institute of Gastroenterology Postgraduate Continuation Course In Gastroenterology

February 21-22, 1969

Del Webb's TowneHouse

Phoenix, Arizona

The purpose of this course will be to relate current physiologic knowledge and newer diagnostic techniques to clinical gastro-enterology with particular attention toward the therapy of the disease.

Partial listing of faculty:

J. EDWARD BERK, M.D.
Professor and Chairman, Department of Medicine, University of California, Irvine, California.

ROBERT J. BOLT, M.D.
Professor and Chairman, Division of Medical Sciences, University of California, Davis, California.

J. EARLE ESTES, M.D.
Director, Nuclear Medicine, Good Samaritan Hospital, Phoenix, Arizona.

PAUL C. JOHNSON, PH.D.
Professor and Head, Department of Physiology, College of Medicine, University of Arizona, Tucson, Arizona.

G. GORDON McHARDY, M.D.
Clinical Professor of Medicine, Director, Division of Gastroenterology, Louisiana State University School of Medicine, New Orleans, Louisiana.

DAVID C. H. SUN, M.D.
Director, Institute of Gastroenterology, Good Samaritan Hospital; Associate Chief of Staff, Veterans Administration Hospital, Phoenix, Arizona.

Registration fee: $25.00 for the entire course, including luncheon, reception and banquet.

For additional information contact:
David C. H. Sun, M.D.
Institute of Gastroenterology
Good Samaritan Hospital
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ROBERT DEAN SPARKS, M.D.

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and a skeletal muscle relaxant shown to have up to a 6-hour span of action[4]...to retain effectiveness even on continued administration[4]...but not likely to have the central effects of tranquilizing compounds.[5]

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Contraindications: Sensitivity to either component. ***Precautions:*** Exercise caution in patients with known allergies or history of drug allergies. If a sensitivity reaction or signs or symptoms suggestive of liver dysfunction are observed, the drug should be stopped. ***Adverse Reactions:*** Occasionally, drowsiness, dizziness, lightheadedness, malaise, overstimulation or gastrointestinal disturbances may be noted; rarely, allergic-type skin rashes, petechiae, ecchymoses, angioneurotic edema or anaphylactic reactions. In rare instances, *Paraflex* (chlorzoxazone) may possibly have been associated with gastrointestinal bleeding. While *Paraflex* (chlorzoxazone) and chlorzoxazone-containing products have been suspected as being the cause of hepatic toxicity in approximately eighteen patients, it was not possible to state that the dysfunction was or was not drug induced. ***Usual Adult Dosage:*** Two tablets q.i.d. ***Supplied:*** Scored, light green tablets, imprinted "McNEIL"—bottles of 100.

References: 1. Batterman, R. C., and Grossman, A. J.: Fed. Proc. *14*:316, 1955. 2. Goodman, L. S., and Gilman, A., ed.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Company, 1965, p. 331. 3. Roth, J. L. A., *et al.*: Gastroenterology *44*:146, 1963. 4. Berman, H. H., *et al.*: Dis. Nerv. Syst. *25*:430, 1964. 5. Friend, D. G.: Clin. Pharmacol. Ther. *5*:871, 1964.

*U.S. PATENT NO. 2,895,877

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PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

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# OF CULTURES	YEAR	% EFFECTIVE
6,723	1962	88.6%
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10,384	1964	88.5%

References: 1. Fowler, J. Ralph et al: Clinical Medicine **70** 547 (Mar.) 1963. 2. Isenberg, Henry D.: Health Laboratory Science **1** 185-256 (July-Aug.) 1964 3. Isenberg, Henry D.: Health Laboratory Science **2** 163-173 (July) 1965.

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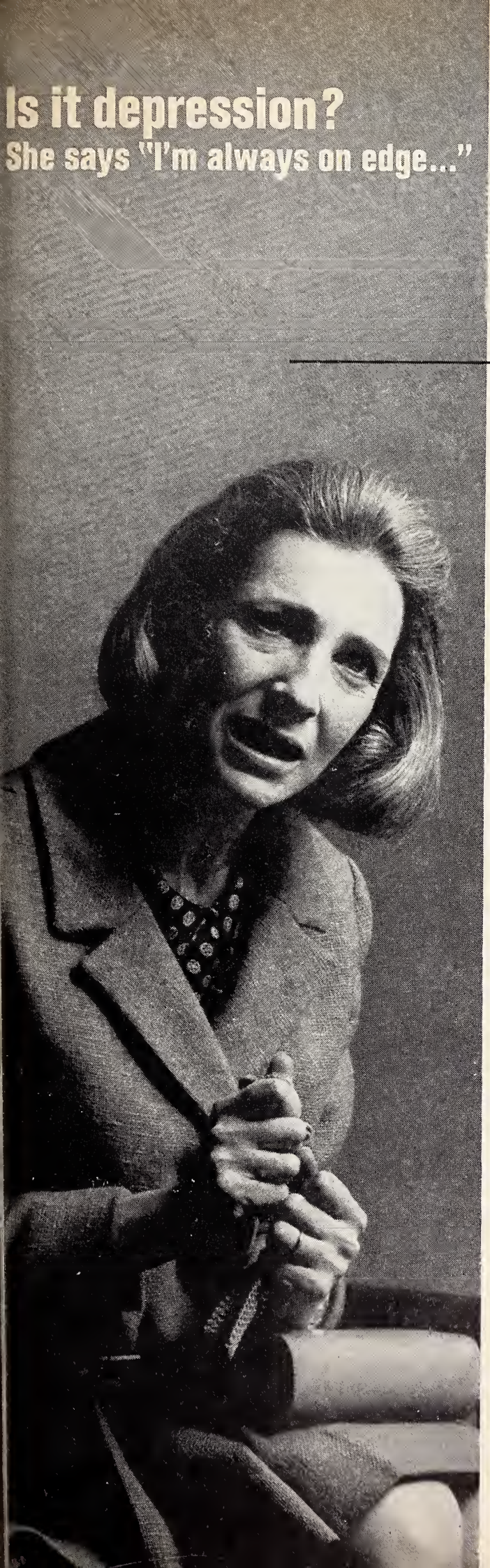
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Indications: Mental depression and mild anxiety accompanying depression.

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Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

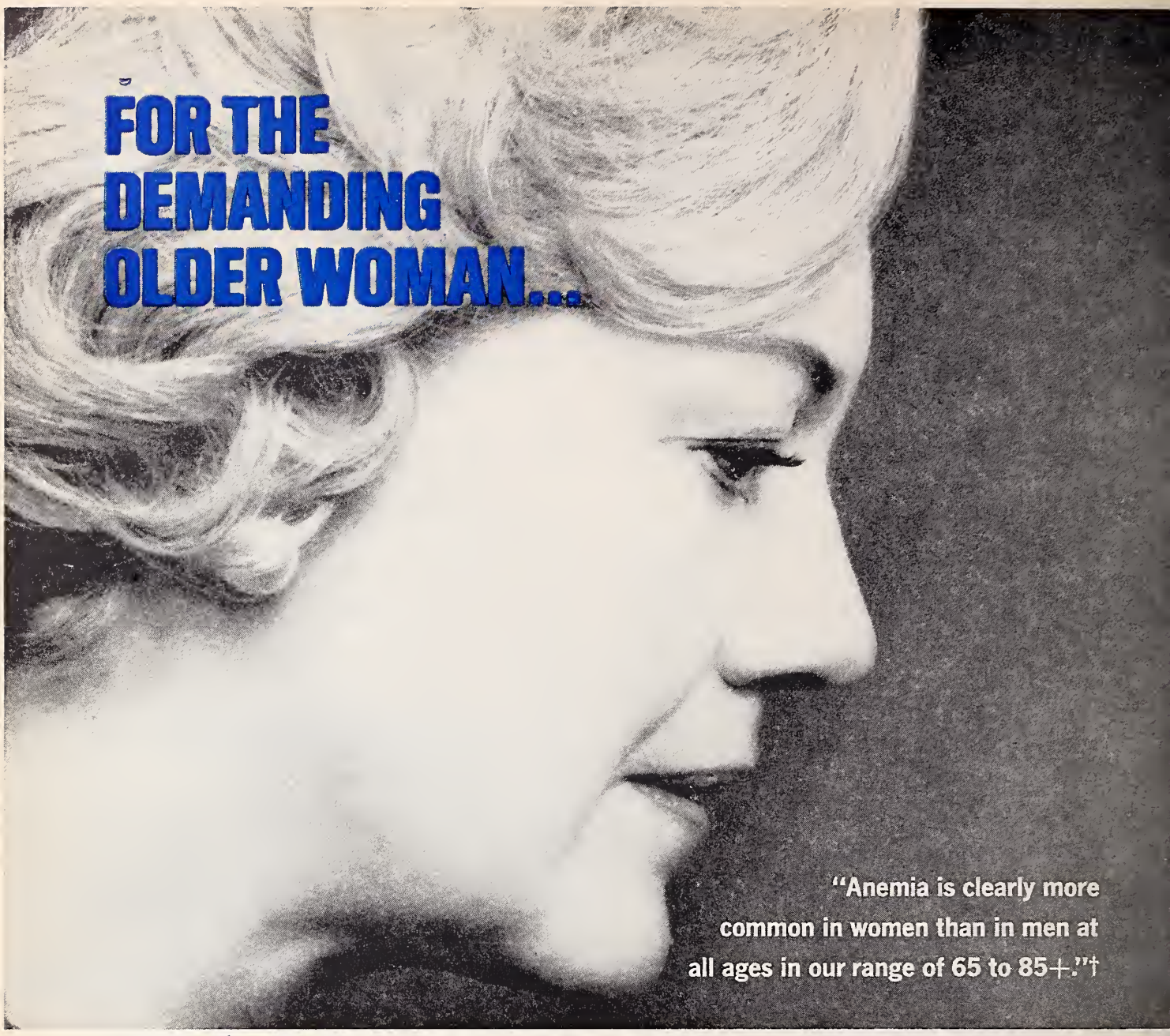
Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

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†Parsons, P.L., Withey, J.L., and Kilpatrick, G.S : Practitioner 195:656, (Nov) 1965.

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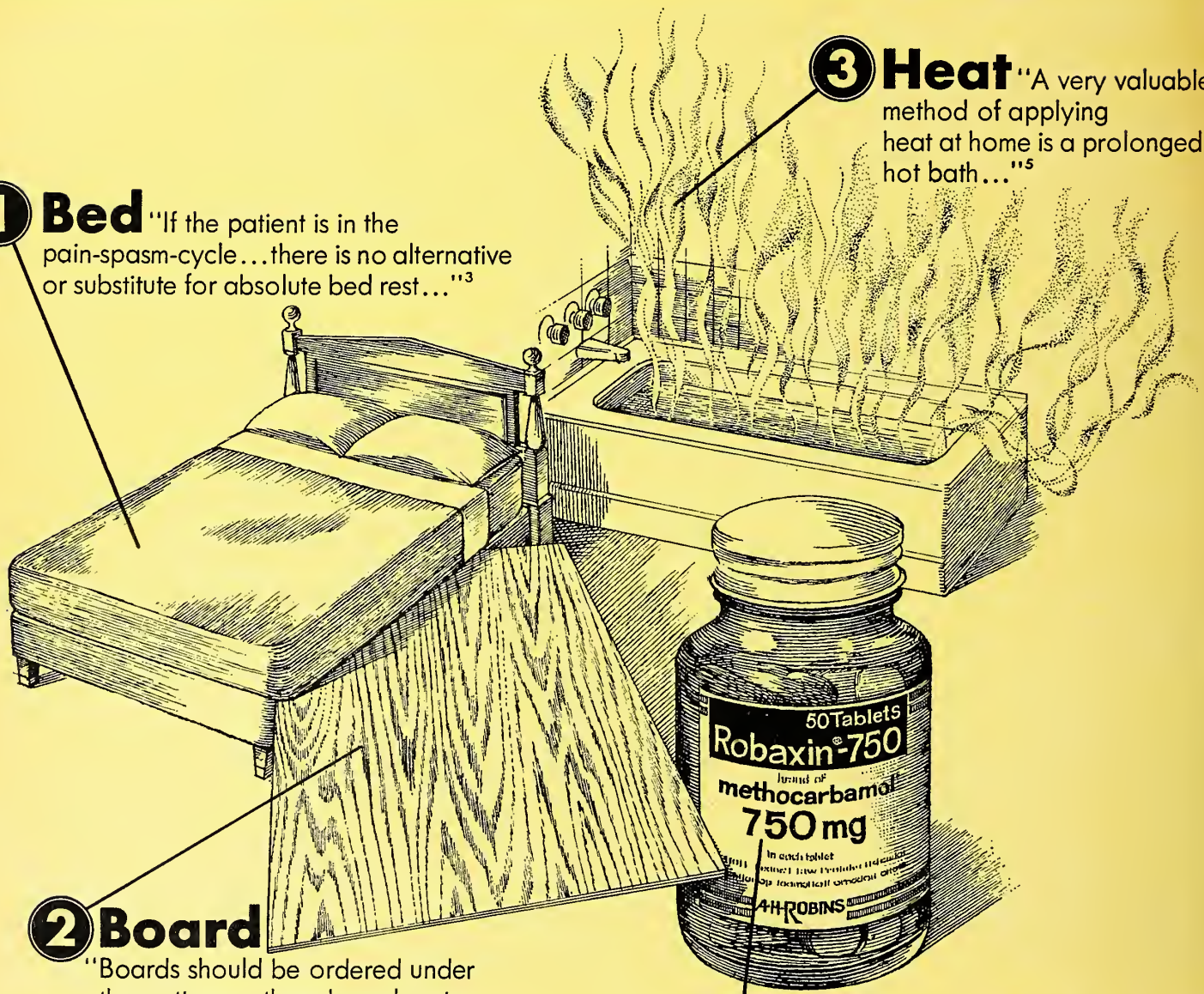
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References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. *18*:26, 1965. (5). Soto-Hall, R.: Med. Sc. *14*:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

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Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

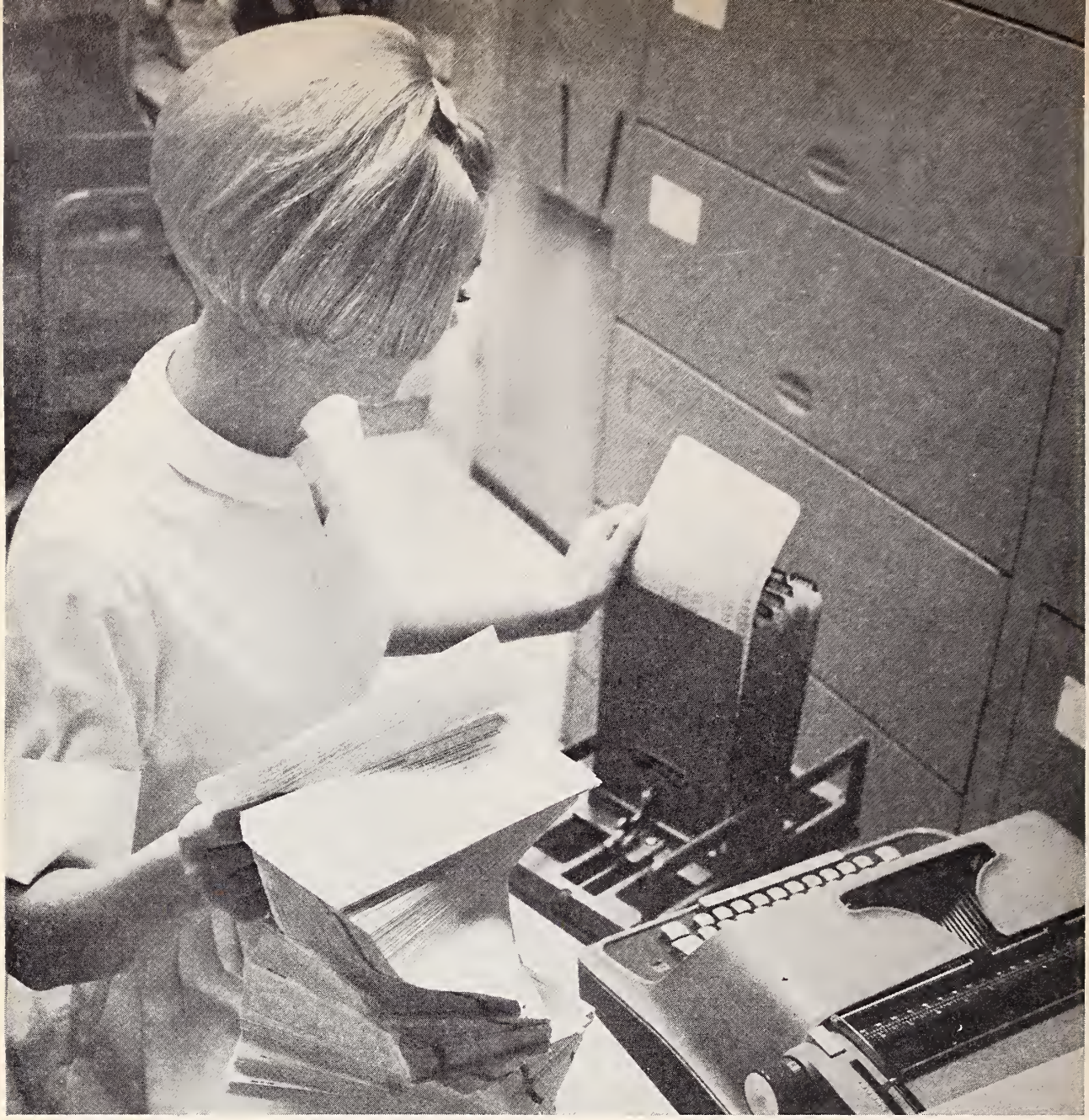
Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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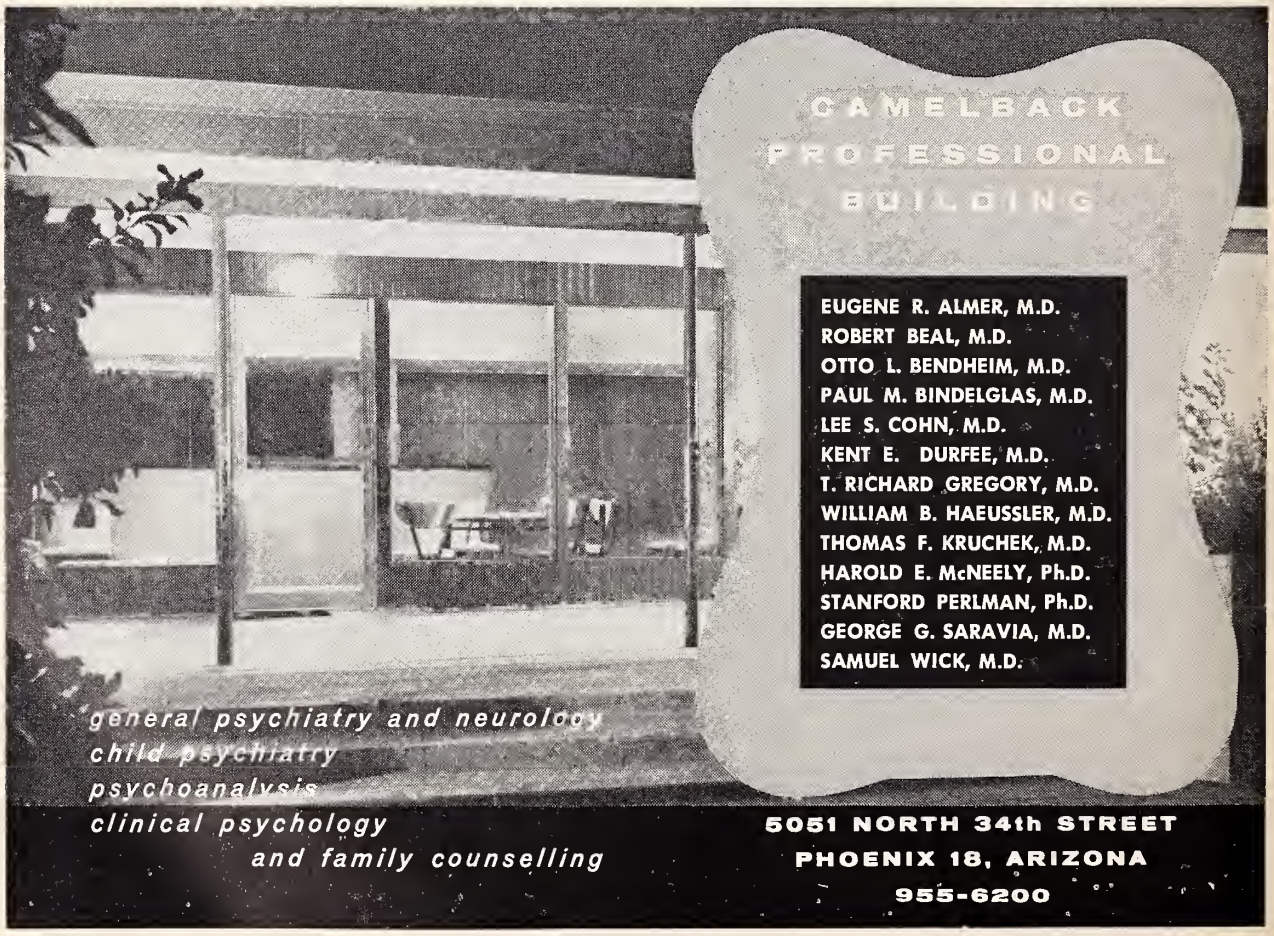
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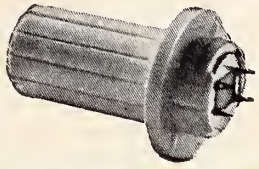
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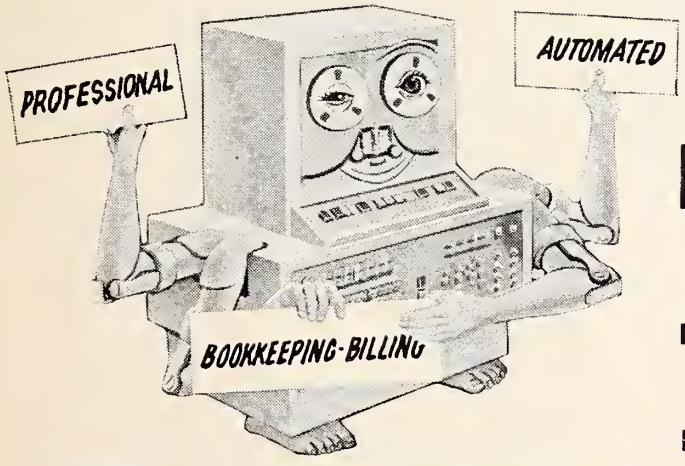
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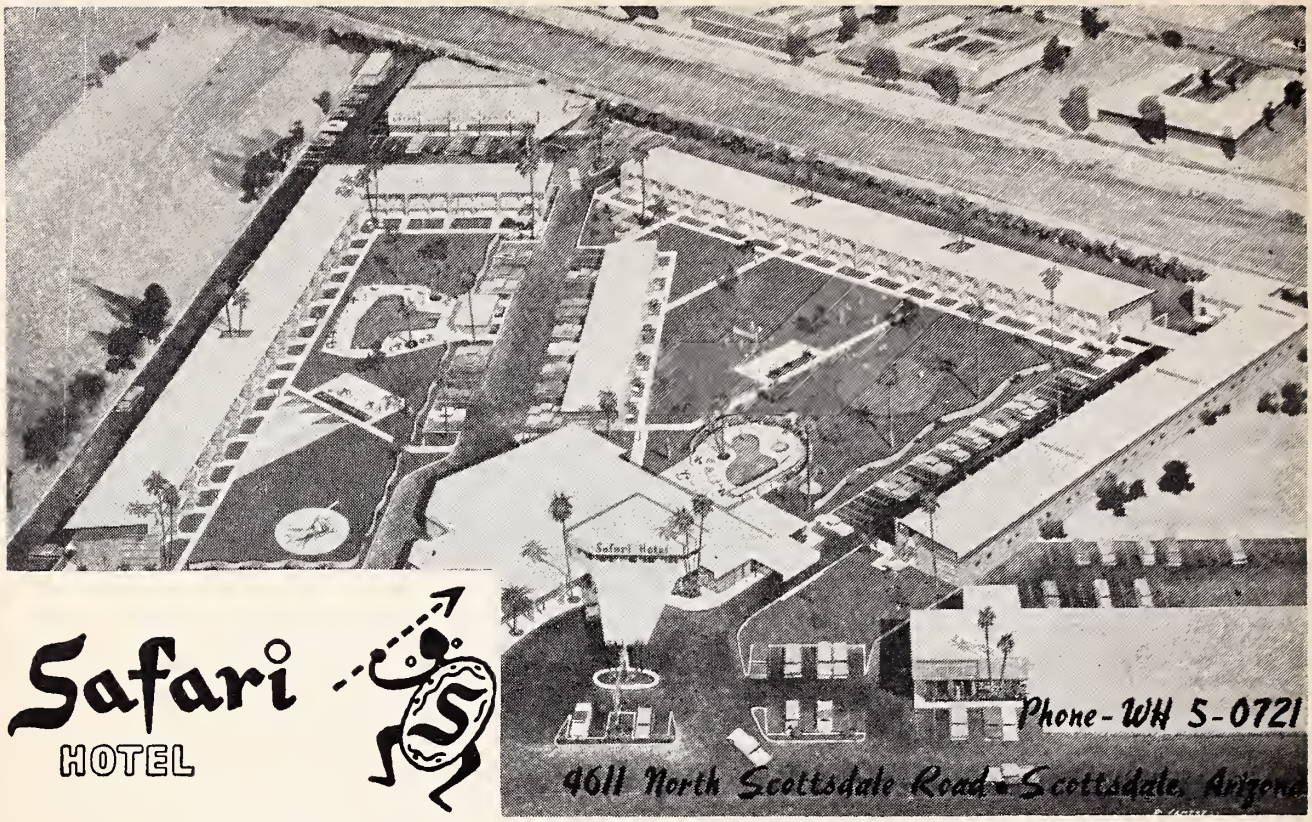
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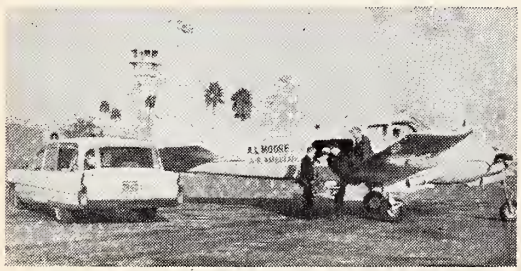
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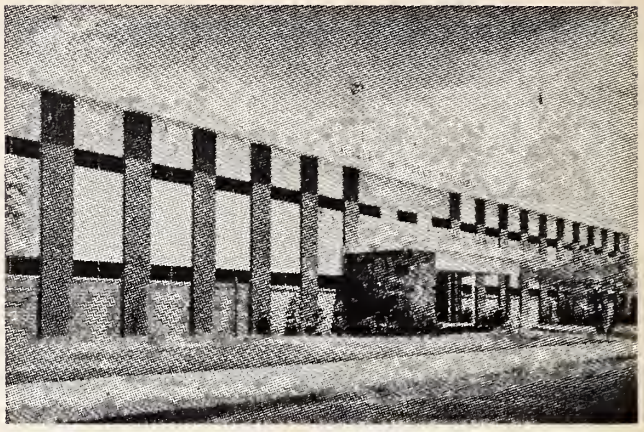
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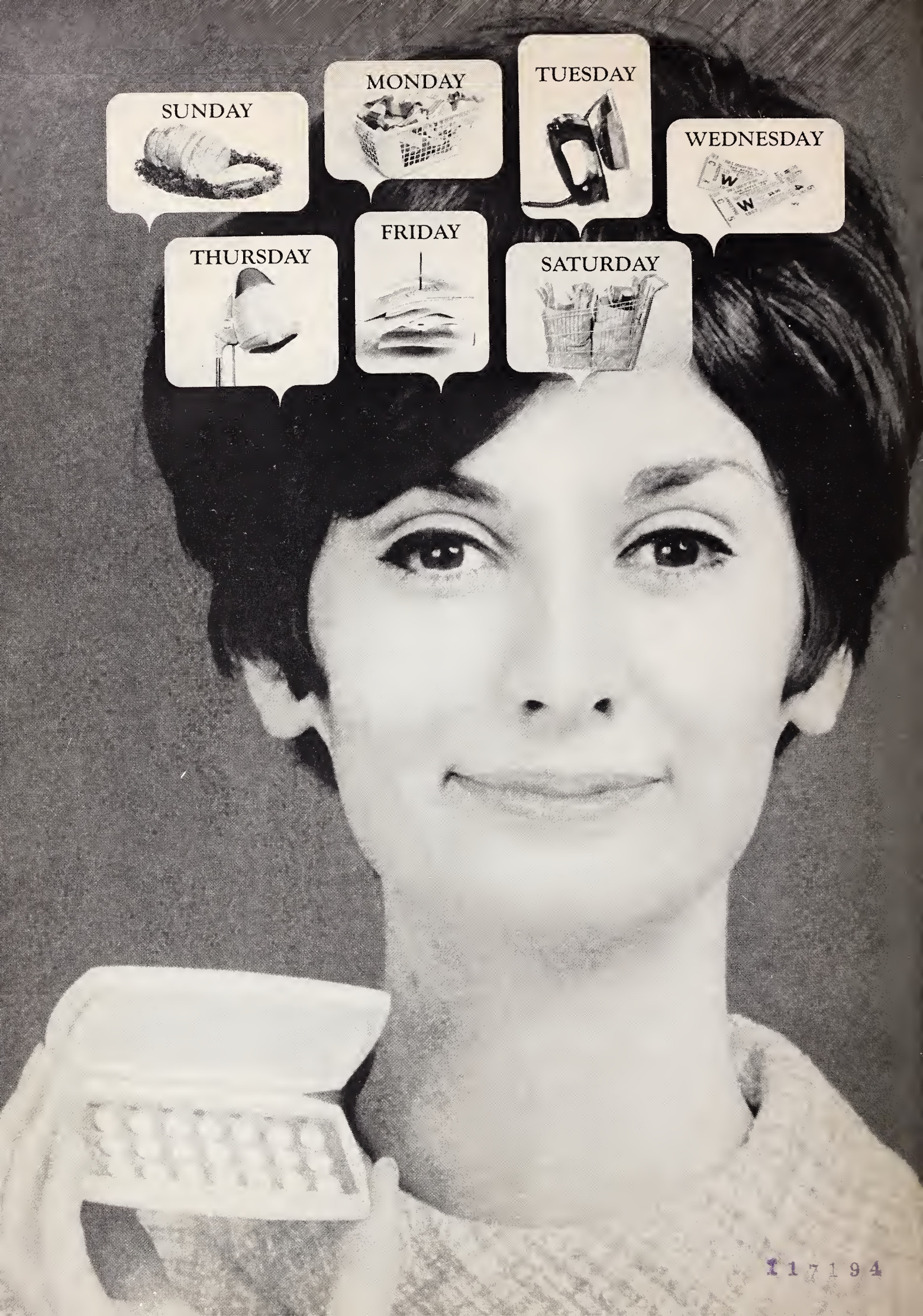
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